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Global HIV/AIDS initiatives, recipient autonomy and
country ownership: An analysis of the rise and decline of
Global Fund and PEPFAR funding in Namibia

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Global Health Policy
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Declaration

I declare that this thesis has been composed solely by myself and that it has not been submitted, in whole or in part, in any previous application for a degree. Except where it states otherwise by reference or acknowledgment, the work presented is entirely my own.

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Abstract

The Global Fund to Fight HIV/AIDS, Malaria and TB and U.S President's Emergency Fund for AIDS Relief (PEPFAR) are global health initiatives (GHIs) that were established in the early 2000s with the mandates to increase global capacity to address HIV and AIDS rapidly. When the two GHIs were created, Namibia was one of the highest recipients of funding from both GHIs. A significant portion of their support to the country went to the Ministry of Health, which was the principal provider of treatment services in the country. Critics have argued, however, that the rise of financial support from the Global Fund and PEPFAR was associated with the creation of new administrative structures and procedures at the country level. This approach raises important questions about the degree to which Namibian health policymakers were able to exercise autonomy in the presence of GHI support.

The aim of this thesis is to analyse the implications for institutional capacity and autonomy at the rise and fall of funding from the Global Fund and PEPFAR to the Ministry of Health concerning financial flows; human resources recruitment; and civil society engagement. With a focus on the changing relationship between the Ministry of Health and the two initiatives, the thesis examines the implications for country ownership and health systems capacity in the

context of decreasing financial support from the Global Fund and PEPFAR.

The field studies for this research was undertaken in 2011- 2012, when the two GHIs had indicated their intentions to scale-down the financial support made available to Namibia. This thesis uses multiple sources of data to qualitatively analyse the influences of Global Fund and PEPFAR support to Namibia from when the two initiatives were first established in 2002 and 2004, respectively, to 2012. A principal source of data was 43 semi-structured interviews conducted in Namibia during a placement with the Directorate of Special Programs in the Ministry of Health in early 2012.

For financial flows, both the Global Fund and PEPFAR channelled and managed their funding through funder-specific structures and procedures that were developed and operated in parallel to existing Ministry of Health operations. Both for financial flows and human resources, initial structures and processes created difficulties for the Ministry of Health's long-term objectives for HIV and AIDS. For civil society engagement, the thesis examined the Ministry of Health's relationship with the Global Fund. At the rise of funding, the Global Fund required the establishment of a new multi-sector coordination structure for HIV and AIDS. This new structure operated at the same time as the existing national coordination structure and was perceived as having undermined the Ministry of Health's role as the primary steward

of Namibia's response. The Global Fund was also criticised for initially funding civil society organisations without making provisions for sustaining their capacity in the event of funding decline.

The findings presented in this thesis indicate that at the rise of financing, the Ministry of Health's engagement with the two HIV and AIDS GHIs initiatives was governed by the objectives of the two initiatives, rather than the long-term health systems goals of the Namibian Government. Their relationships with Namibia had an adverse impact on the Ministry of Health's autonomy in making decisions on the national response to HIV and AIDS. The initial operations of the GHIs also had negative implications for Namibia's ability to sustain the health systems capacity they had helped to increase.

Lay Summary

Building strong foundations for health systems interventions is essential for conditions, such as HIV and AIDS, which are treatable, but are not curable. This thesis aims to contribute to research on how international donors to HIV and AIDS engage with recipient country health systems. It examines the implications for country ownership in Namibia's relationship with the Global Fund to Fight AIDS, Tuberculosis and Malaria and the U.S President's Emergency Plan for AIDS Relief (PEPFAR).

In conjunction with the Namibian Government and other stakeholders, the assistance from the Global Fund and PEPFAR facilitated a rapid increase in HIV and AIDS prevention, treatment and care services in the country. When interview data for this thesis was collected in early 2012, respondents from the Ministry of Health indicated that financial support from the Global Fund and PEPFAR to Namibia was on the decline. This decrease in funding to Namibia from both initiatives was happening despite the country's position as having one of the highest HIV and AIDS prevalence in the world.

With the transition in funding as a cross-cutting theme, this thesis examines the administrative structures and practices that were adopted in relation the two initiatives at the rise of Global Fund and PEPFAR funding to Namibia. The thesis then examines the implications that these

structures and practices had for the Ministry of Health when financing from two GHIs was on the decline. The thesis has a thematic sub-focus on financial management and flows, human resources management, and civil society engagement. The research primarily draws on interview data that was collected from February to June 2012, during a placement with the Ministry of Health. In total, there were 43 semi-structured interviews with representatives from the Ministry of Health, Global Fund and PEPFAR. The thesis also draws on interviews with other stakeholders in the national HIV and AIDS response, such as members of other government agencies, civil society agencies, and international development agencies.

The results of the research indicate that when the Global Fund and PEPFAR first started to provide funding to Namibia, the administrative structures that governed its relationship with the Ministry of Health were not aimed at encouraging country ownership. Through focusing on the rise and fall of Global Fund and PEPFAR support to Namibia, the research shows that several decisions that appeared to be sensible when the Ministry of Health first started to engage with the two initiatives proved to be problematic when the country was faced with a decline in financial support from the two initiatives. The initial operational decisions ended up having negative implications for the Ministry of Health's ability to sustain the capacity gained with support from the two GHIs.

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1. Introduction

1.1 Why Examine Global Fund and PEPFAR in Namibia?

This thesis is an examination of Namibia's relationship with two global health initiatives (GHIs): The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the U.S President's Emergency Fund for AIDS Relief (PEPFAR). The Global Fund and PEPFAR are part of a growth in issue-specific GHIs, which became prevalent in international development for health as from the late 1990s (McCoy et al., 2009; Ravishankar et al., 2009). In an analysis of development aid data from the Organisation for Economic Cooperation and Development (OECD), Ravishankar et al. (2009) found that international assistance to health increased from US\$5.6 billion in 1990 to US\$21.8 billion in 2007. Their analysis further revealed that health aid doubled in the 11 years between 1990 and 2001, but and then doubled again in the six years between 2001 and 2007 (Ravishankar et al., 2009). According to Ravishankar et al. (2009), a disproportionate increase in health aid that occurred post-2000 was mainly due to funding specifically targeted for HIV and AIDS (Ravishankar et al., 2009).

The Global Fund and PEPFAR have been two of the most prominent global health initiatives (GHIs) for HIV and AIDS (Bilimoria, 2012; McCoy et al., 2009; Riddell, 2007). The Global Fund was

established in 2002 and PEPFAR was created in 2004. By 2010, the Global Fund and PEPFAR were the sources of more than 20% of total international funding for HIV and AIDS (Truong, 2013; Voelker, 2010). This thesis reflects a policy and academic interest in understanding the impacts of the two GHIs on the health systems of countries that have received their support (Amaya et al., 2014; Biesma et al., 2009; Kapilashrami and McPake, 2013; WHO Maximising Positive Synergies Collaborative Group, 2009).

The volume of funding from HIV and AIDS GHIs means that they have significant potential to dictate the health agendas of recipient countries (Caines et al., 2004; Hanefeld et al., 2007; Sridhar and Batniji, 2008). Initiatives such as the Global Fund and PEPFAR may also have the potential to create the dilemma that recipients might not be able to sustain the levels of increased funding and operational capacity facilitated by the presence of GHIs (Caines et al., 2004). Understanding interactions between country health systems and GHIs can help national policy-makers determine how to minimise their negative impacts and sustain their positive effects (Walker, 2009; WHO Maximising Positive Synergies, 2009).

Due to its high HIV and AIDS prevalence, the country Namibia was initially one of the highest per capita recipients of funding from both the Global Fund and PEPFAR (Hecht et al., 2010; Youde, 2010). At the time when interview data for this thesis was collected in 2012, it was

evident that the Global Fund and PEPFAR had changed their starting funding priorities. They had made a shift towards funding countries on their perceived ability to pay for their health interventions, rather than primarily on the basis of population health needs as had initially been the case (110th USA Congress, 2008; The Global Fund, 2013a, 2012a). Both GHIs had also moved away from their original message of a focus on the rapid scale-up of HIV and AIDS interventions and began to emphasise issues of country ownership and sustainable health interventions (110th USA Congress, 2008; Holmes et al., 2012; The Global Fund, 2013a, 2012a). Their shifting priorities had a direct impact on Namibia.

With a focus on Global Fund and PEPFAR funding to Namibia, this thesis examines the changing relationship between the two initiatives and the Ministry of Health. The thesis aims to answer the question: To what extent was Namibia able to exercise ownership in its engagement with the Global Fund and PEPFAR, given the rise and fall of GHI funding to the country? In this thesis, the recipient country's health system is the central unit of analysis. Given its pre-GHI role as the primary steward of the Namibian health sector, this thesis looks at the issue of ownership from the perspective of the Ministry of Health as the main unit of analysis. The underlying research sought to determine the extent to which Namibia was able to mitigate the potentially undermining impacts of the Global Fund and PEPFAR on country ownership and institutional autonomy.

For Namibia, the questions posed by this thesis are important because the country experienced a very rapid increase in funding from the Global Fund and PEPFAR during the 10-year period covered by this thesis. External funding as a percentage of total health sector spending increased in Namibia from 3.8% in 2001 to 21.7% in 2009 (Ministry of Health, 2010). More than 90% of the increase in external funds to the country's health sector during this period has been attributed to contributions from the Global Fund and PEPFAR (Ministry of Health, 2010). A principal source of data was 43 semi-structured interviews conducted in Namibia during a placement with the Directorate of Special Programs (DSP) in the Ministry of Health from February to June 2012. Observations gained from participation in Ministry of Health meetings and other discussions concerning the two GHIs supported the interview findings. Data unique to the Namibian health system and its relationship to the Global Fund and PEPFAR also came from documents such as newspaper articles, policy and strategy papers, as well as books and peer-reviewed journal articles.

By their initially defined health objectives, this chapter introduces the Global Fund and PEPFAR within global discussions on country ownership in the engagement between government recipients and external donors to the health sector. The examination of national ownership, in particular, draws on the Paris Agenda for Aid Effectiveness, which is an international commitment aimed at promoting

country ownership, and to which the Global Fund, PEPFAR, and the Namibian Government are all signatories (Organisation for Economic Co-operation and Development (OECD), 2008). In the three primary results chapters (chapter five, six and seven), this thesis first evaluates the extent to which the two GHIs influenced Ministry of Health autonomy to make decisions on financial flows; human resources recruitment; and civil society engagement at the rise of their funding to the country. For these three functions, the thesis then examines the implications for country ownership and health systems capacity in the context of decreasing financial support from the Global Fund and PEPFAR.

1.2 Defining GHIs

This thesis mainly uses the term global health initiatives (GHIs), which evolved from other names such as Global Health Partnerships (GHPs), Global Health Programmes, Public-Private Health Partnerships, and Global Public-Private Partnerships, amongst others (Biesma et al., 2009; Buse and Harmer, 2007; Walker, 2009; WHO Maximizing Positive Synergies Collaborative Group, 2009). Some of the other names for GHIs, particularly those using the term "partnership", have been found to be problematic. This discursive construction "disguises the unequal power relations between the various actors", and allows for a perception of adverse impacts of these 'partnerships' as regrettable, but unavoidable

(Buse and Harmer, 2004, p. 51). The word “partnership” implies an equal sharing of rewards, risks and power in the relationship, which does not play out in the real world (Walker, 2009). The use of the term GHIs does not necessarily expose these power differentials, in fact, it may mask them, but at least it does not imply that they do not exist.

There appears to be no consensus on whether GHIs have a negative or positive impact on the settings in which they implement their interventions. Whether the effects of GHIs are perceived as positive or negative appears to depend on a variety of factors. These factors include the type of GHI; the sort of response it supports; and social and political context of the country within which the GHI operates (Atun et al., 2011; Biesma et al., 2012; Buse and Harmer, 2007; Cailhol et al., 2013; WHO Maximizing Positive Synergies Collaborative Group, 2009). Table 1.1 provides an overview of the perceived negative and positive impact of HIV and AIDS GHIs as reflected in the literature reviewed for this thesis.

Table 1-1 Positive and Negative Impacts of GHIs

Positive Impacts	Negative Impacts
<ul style="list-style-type: none"> • Succeed in getting health issues onto national and international agendas • Good at leveraging additional finances for target interventions • Increase access to health services to population groups who might otherwise not be able to afford them • Stimulate research and development on health issues • Strengthen national health policy process and content • Augment health service delivery and capacity 	<ul style="list-style-type: none"> • Distort country health priorities • Inefficiently implement parallel and duplicate delivery of services • Numerical focus on targeted interventions, which prevents a holistic approach to health systems strengthening • Produce supply-induced demand, which is not necessarily a reflection of country disease burden • Poach workers from public sector and with better pay packages

- | | |
|---|--|
| <ul style="list-style-type: none"> • Establish international norms and standards • Secure a reduction in prices for some medical commodities • Encourage countries to strengthen program monitoring and accountability • Boost wider stakeholder participation in health delivery and decision-making | <ul style="list-style-type: none"> • Increase inequality in services access between services for target and non-target diseases • Inadequate use of country governance and management structures and processes • They waste resources through failure to harmonise their activities with country systems and other donor activities • Do not always take into account the full cost of interventions • Disbursements are often less than commitments • Have a “one-size fits all” approach that does not always consider country diversity |
|---|--|

The issue of distortion of national health priorities is particularly prominent in discussions on adverse impacts of HIV and AIDS GHIs (Biesma et al., 2009). Buse and Harmer (2007) note that by nature GHPs are issue specific and quick results oriented in a way that rarely takes into account the whole system. Other bad habits highlighted by Buse and Harmer (2007) include the failure of GHIs/GHPs to harmonise their practices and procedures with one another and other donors, which leads to duplication and waste in various health systems functions. Staff associated with GHI interventions are often doubly held accountable, but often better compensated by GHIs than their public-sector counterparts.

GHIs such as the Global Fund and PEPFAR have been found to distort country health priorities by distracting the government from addressing larger health system issues as result of their significant financial contributions to one health problem, namely HIV and AIDS. The output-based performance measures of the Global Fund and PEPFAR

have also been found often occur at the expense of wider health system improvements and country ownership as the recipient countries clamber to meet the measures of success defined by the GHIs (Buse and Harmer, 2007; McCoy et al., 2009). The Global Fund and PEPFAR have been found to isolate functions such as planning, management, monitoring and evaluation systems from existing country processes (Amaya et al., 2014; Biesma et al., 2009; Collins and Beyrer, 2013; Kapilashrami and Hanefeld, 2014). By operating through parallel mechanisms of accountability, often unrelated to those of the recipient countries, GHIs can function with limited transparency in a way that hinders effective partnerships and country ownership.

1.3 Origins and Priorities of the Global Fund and PEPFAR

The Global Fund and PEPFAR have been defined as originating from the global attempts to assist recipients to achieve their development growth and poverty-reducing goals as reflected by the Millennium Development Goals (MDGs) (Komatsu, 2007; Mills et al., 2010; Travis et al., 2004). The MDGS were established as eight global targets to substantially alleviate extreme poverty through addressing issues such as hunger, disease, and gender inequities by the year 2015 (The United Nations, 2000). These targets were made formal in September 2000, at the Fifty-fifth session of the United Nations Assembly (The United

Nations, 2014). The MDGs sought to decrease the overall global burden of infectious diseases in the poorest parts of the world. The guiding policy document, however, only specifically referred to HIV, AIDS, Tuberculosis (TB) and malaria (The United Nations, 2000). The global goals for HIV and AIDS were encapsulated by MDG6, which had two primary targets. Target 6A committed UN member nations to "have halted by 2015 and begun to reverse the spread of HIV and AIDS". Target 6B committed the UN community "to achieve, by 2010, universal access to treatment for HIV and AIDS for all those who need it" (The United Nations, 2000).

According to Ramsay (2002), the idea to establish an international funding mechanism to address HIV/AIDS, TB and Malaria (the Global Fund), first gained traction in July 2000 at the Group of Eight (G8) Summit in Okinawa, Japan. After the Millennium Development Goals (MDGs) had been adopted, the concept of the Global Fund was then unanimously endorsed at the UN General Assembly Special Session on HIV/AIDS in June 2001 (Ramsay, 2002). Subsequently, in July 2001, at their Summit in Genoa, Italy, the G8 leaders committed US\$1.3 billion to funding the initial operations of the Global Fund (Ramsay, 2002).

The Framework Document of the Global Fund constructs the GHI as seeking to contribute to poverty reduction as represented by the MDGs through facilitating financial resources to address HIV and AIDS, TB and Malaria (The Global Fund, 2001a). When the Global Fund first came into operation, it prioritised proposals aimed at scaling up interventions that

already existed in the countries that applied for funding. As basic principles to guide the country process, the Global Fund had two main requirements (The Global Fund, 2001):

1. The Global Fund will base its work on programs that reflect national ownership and respect country partnership-led formulation and implementation processes.
2. The Global Fund will promote partnerships among all relevant players within the country, and across all sectors of society. It will build on existing coordination mechanisms, and develop new and innovative partnerships where none exist.

Its founding documents state that “the Global Fund's purpose is to attract, manage and disburse resources to fight AIDS, TB and malaria. It does not implement programs directly, relying instead on a broad network of partnerships with other development organisations on the ground to supply local knowledge and technical assistance where required”. It sought to address gaps in country efforts to fight HIV and AIDs, TB and Malaria. It was also meant to strengthen underlying health systems by financing programs that complement those of other donors.

PEPFAR, on the other hand, was first introduced in President George W. Bush's State of the Union Address in February 2003 and signed into law that May. PEPFAR was initially defined by the U.S Government as a five-year, US\$15 billion initiative to expand HIV prevention, care, and treatment services to 15 focus countries, mostly in sub-Saharan Africa. In 2008, the U.S Congress authorised another phase

of PEPFAR funding, also spread over five years (2009-2013). PEPFAR phase 2 set aside US\$48 billion to combat global HIV/AIDS, tuberculosis, and malaria; US\$39 was meant exclusively for HIV/AIDS programs (110th USA Congress, 2008). Soon after the authorization of phase 2, the funding for the PEPFAR initiatives was subsumed by the U.S Government's Global Health Initiative (GHI), which was introduced by President Barack Obama when he came into office in 2009 (Gostin, 2010). Through the GHI, President Obama pledged US\$63 billion over six years (fiscal years 2009-2014) to global health support from the U.S Government. This amount consisted of US\$51 billion for PEPFAR (HIV/AIDS, TB and malaria) and \$12 billion for all other health issues (Gostin, 2010, p. 789).

The goal of contributing to the MDGs was also implicit in the initial authorization of PEPFAR funding (108th USA Congress, 2003). In addition to the mention of MDG6, as part of the initial PEPFAR congressional approval, the U.S Government also specifically allocated funding to the Global Fund. This allocation constituted the U.S Government's G8 commitment to funding the Global Fund. The title of the congressional approval for PEPFAR Phase 1 (the United States Leadership Against Global HIV and AIDS, Tuberculosis and Malaria Act of 2003) also mirrors the full name of the Global Fund (108th USA Congress, 2003).

Table 1-2 Overview of Global Fund and PEPFAR

	Global Fund	PEPFAR
Type	Public-Private Partnership	Bilateral donor
Start Date	2002	2003 (the fiscal year 2004)
Focus Health Issue	HIV/AIDS, tuberculosis, malaria	HIV/AIDS
Priority	Flexible funding for priorities set by country stakeholders	Achieving programmatic targets set by US Congress
Management System	Global Fund secretariat and Board, Country Coordinating Mechanisms, and Local Fund Agents	US Global AIDS Coordinator, country teams coordinated through US embassy
Major Funders	Bilateral donors, private philanthropy donations, private sector	US Government, with funding approved yearly by US Congress
Funding Allocations	Assessment of country proposal by Technical Review Panel and performance-based assessment of country reports	Predetermined earmarked funding
Types of Interventions Funded	HIV, TB, and malaria services; health systems strengthening	HIV and AIDS prevention, treatment, care and support; health systems strengthening; education and other development interventions

Principal Recipients	Governments, civil society	NGOs, Governments
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The year 2015 represented a threshold in discussions on international development objectives. The post-2015 Development Agenda was agreed in September 2015. The 17 Sustainable Development Goals, which are a follow-on to the original 8 MDGs have a specific and directed focus on sustainable development. The message that the Sustainable Goals convey is that it is important to recognise and examine the processes by which goals are achieved and not only focus on outcomes (United Nations, 2015). The new targets have a focus on sustainable development, which indicates that this was an element missing in the initial goals. The MDGS had a focus on providing as much money as possible to tackle problems of poverty. The new targets recognise that it is not just about providing lots of money for short-term goals. Sustainability came out as an important theme (United Nations, 2015). In relation to health, the Sustainable Development Goals reflect the recognition that it is important to also look at the systems and foundations that allow for a lasting impact on health interventions (Balabanova et al., 2010; Goldberg and Bryant, 2012; Hafner and Shiffman, 2013; McCoy, 2009; Ooms et al., 2008; Pearson et al., 2009; WHO Maximizing Positive Synergies Collaborative Group, 2009).

The Global Fund receives most of its funding through replenishment meetings held every two years. Before these meetings, the Global Fund Board of Directors sets targets for how much it wishes to raise to achieve its planned activities for the two years following the meeting (The Global Fund, 2001). In November 2010, the Global Fund held a replenishment meeting in New York City for which it set a target of US\$20 billion. It only ended up receiving US\$11.7 billion in pledges (Boseley, 2011; Voelker, 2010). As a direct result of the lower-than-expected promises, in November 2011, the Global Fund cancelled Round 11, which was the upcoming call for applications. Had this funding round continued as planned, it was supposed to provide new grant money for 2011 through 2013 (Health Gap, 2011; Truong, 2013).

Soon after the Global Fund Board made the decision to cancel Round 11 in Accra, Ghana, in November 2011, the Executive Director at the time, Michel Kazatchkine was quoted in the UK Daily newspaper, the Guardian, attributing the decision to the 2008 Financial Crisis (Boseley, 2011):

It is deeply worrisome that, inadvertently, the millions of people fighting with deadly diseases are in danger of paying the price for the global financial crisis. There are millions of people dependent on Global Fund resources to stay alive and healthy, and the Global Fund will redouble its efforts to increase the available funding to continue to scale-up HIV, TB and malaria interventions.

Within the preceding quote, the Executive Director recognises that Global Fund support before the financial crisis led to people being dependent on

its financial resources to stay alive. On behalf of the Global Fund, he then promises that there will be increased efforts to continue scaling up funding to allow for the continued scale-up of interventions. The cancellation of Round 11, however, marked a transition in the Global Fund's stated objectives and intentions for the funding it granted to recipient countries.

As a replacement for the funding that countries had expected from Round 11, the Global Fund Board introduced the Transitional Funding Mechanism (TFM), which it defined as seeking to achieve the following (The Global Fund, 2012a):

to make resources available so that current recipients of Global Fund financing can continue essential prevention, treatment and care services without disruption (p.2).

When it was first announced, the Global Fund labelled the TFM as a temporary measure (The Global Fund, 2012a). However, a year after the cancellation of Round 11, in November 2011, the Global Fund Board adopted the rule that each year, 55% of all Global Fund resources must go to low-income countries (Aidspan, 2013). As a direct follow-up to the 55% rule, the Global Fund then established its New Funding Model in 2012. The Global Fund's New Funding Model's (NFM) basic framework divided up the available funding based on a country's composite score of the burden health issues, and ability to pay, based on Gross National Income (GNI) per capita (The Global Fund, 2013).

At its meeting in November 2011, the Global Fund Board adopted a new strategy for the period 2012-2016. Whereas the original Framework emphasised the rapid scale-up of financial resources to address the three focal global fund health issues to produce quick health results; the New Strategy placed greater emphasis on sustaining the health results achieved with financial support from the Global Fund. Within the 2012-2016 Strategy, the Global Fund aspired to contribute substantially to international goals by saving 10 million lives and preventing 140-180 million new infections from HIV/AIDS, tuberculosis and malaria between 2012 and 2016 (The Global Fund, 2013).

According to the Global Fund, as reflected in Strategic Objective 1 of the New Strategy, alignment with national strategies and systems is a fundamental principle of aid effectiveness, which contributes to enhanced country ownership. The 2012-2016 Global Fund Strategy admitted that there remained much more room for Global Fund practices to be better aligned with national strategies and systems (The Global Fund, 2013).

In its New Strategy, the Global Fund defines itself as having been founded in a time of emergency to respond to the epidemics and build on the momentum created by the MDGs. It argues, however, that initial ten years were just a start and there was a lot of work still needed in order to attain the MDGs. The primary purpose of Strategic Objective 5 in the New Strategy is to, therefore, sustain and expand the gains from the first ten years to achieve the MDGs and Global Fund's targets. "A failure to

secure the necessary resources would result in an opportunity lost and the risk of unravelling the progress made to date (The Global Fund, 2013).”

In the Guiding Strategy for PEPFAR phase 1, the purpose of the initiative was defined as focusing on "rapidly scaling up" prevention, treatment, and care activities, primarily for HIV and AIDS (Office of the U.S. Global AIDS Coordinator, 2009). PEPFAR was originally designed as an emergency initiative, operating with considerable funds, immediate roll-out, fast scale-up, and top-down technocratic administration. PEPFAR Phase 1 (2004-2008) never really had “country ownership” as one of its clear overriding objectives. The Strategy for the second phase of PEPFAR (2009-2013), however, sold itself as having a "focus on transitioning from an emergency response to promoting sustainable country programs." The strategy emphasised that for them to be sustainable, "programs must be country-owned and country-driven" and "must address HIV/AIDS within a broader health and development context" (110th USA Congress, 2008; Office of the U.S. Global AIDS Coordinator, 2009).

In 2012, in an article primarily authored by staff from the OGAC (including Eric P. Goosby, the U.S Global AIDS Coordinator at the time), this is how PEPFAR administrators reflected on the impacts of the 2008 Financial Crisis (Holmes et al., 2012):

...the worldwide economic crisis has raised uncertainty about whether the global HIV response will be able to make full use of the new scientific gains and continue to support existing interventions... The people who have been supported by global HIV/AIDS support need continuing support, with consistent access to health services, while their countries' health systems maintain the capacity to accommodate other people who are newly in need of treatment (p.1554).

Similar to the Global Fund Board, PEPFAR administrators recognised that the people that had been put on treatment with donor support needed to be kept on treatment. They also acknowledged that there would be a rise in new people who would need access to treatment. One of PEPFAR's policy responses to the Financial Crisis was the development of the Impact and Efficiency Acceleration Plan in early 2011. PEPFAR administrators characterised the plan as a "comprehensive strategy to implement [PEPFAR's] response to the global economic crisis effectively (Holmes et al., 2012, p. 1554). As part of the Efficiency Plan, PEPFAR signed partnership frameworks with more than twenty countries. According to Holmes et al. (2012), the partnership frameworks map out five-year strategic partnerships between PEPFAR and governments, Global Fund, and other in-country partners. The frameworks were meant to be aligned closely with existing or evolving national strategic plans for HIV and other health services.

1.4 Thesis Framing of Country Ownership and Autonomy

Both the Global Fund and PEPFAR have faced criticisms for some of their impacts on country health systems, especially regarding procedures and systems for accountability. The two initiatives have frequently been found to have donor-specific reporting requirements and operational procedures (Amaya et al., 2014; Biesma et al., 2009; Bilimoria, 2012; Cailhol et al., 2013; Collins and Beyrer, 2013; Oomman et al., 2008). The criticisms levelled against the Global Fund, and PEPFAR, particularly concerning country ownership and autonomy are reflective of ongoing debates on the function and value of external funding to the health sector.

Health systems reside in nation-states, and country-level dynamics will ultimately determine prospects for a country-specific health agenda. However, global actors such as GHIs can influence national agendas, control considerable financing for country specific health systems and are sources of health policy ideas (Balabanova et al., 2010; Cohen et al., 2013; Druce and Dickinson, 2008a; Hafner and Shiffman, 2013; World Health Organization, 2007). Easterly (2008) has argued that providers of foreign aid have historically struggled with the question of how to deal with the governments in the recipient of assistance country:

The central dilemma is that donors want to give money to states led by what the donors think is a good government, yet at the same time, they believe that the "country" (always meaning the

government) should “own” its homemade approach to development. There is an inescapable contradiction between the donors' imposition of conditions on what it takes to be a good government and the logical implication of “ownership” that the “country” will decide on its own what is a good government (Easterly, 2008, p.26).

Thus one of the primary and prevailing concerns of critics the aid giving policy architecture relates to their tendency to constrain the autonomy of the governments of the countries that receive their funding (Whitfield and Fraser, 2009a):

Western agencies have restricted the policymaking options of aid-receiving governments by demanding that their money is spent on their priorities and particularly by insisting that, in return for much-needed finance, recipient governments change their economic and social policies. Critics argue that imposing policies, sequences of reform, and spending priorities has done more harm than good, overriding national sovereignty, damaging democracy, displacing local concerns and solutions (p.2).

The tendency for western agencies to constrain the autonomy of sovereign governments in the implementation of plans to meet aid objectives is, however, often justified by seeking to make the transfer of assistance more effective (Oliveira Cruz and McPake, 2010). The Paris Agenda represents an example of the country ownership framing of the aid effectiveness agenda. It is widely touted as the best example of an attempt to promote country ownership for international aid for health (110th USA Congress, 2008; Booth, 2008; Buiter, 2007; Goldberg and Bryant, 2012; Government of the Republic of Namibia, 2008; Hafner and Shiffman, 2013; Shorten et al., 2012; The Global Fund, 2013a).

The Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008) make up the Paris Agenda. The Paris Declaration is an international health agreement which was signed on the 2nd of March 2005. Its aim was to provide a “resolution to take far-reaching measurable actions to reform the way aid is delivered and managed ahead of the five-year review of the MDGs, and beyond (P.1, section 1)” (OECD, 2008). The Declaration affirmed a commitment to accelerate progress in six main areas (P.1, Article 3) (OECD, 2008). The Paris Declaration was signed by government representatives from low- and high-income countries and by the heads of multilateral and bilateral agencies. The Global Fund, PEPFAR, and the Namibian Government were all signatories to it (Organisation for Economic Co-operation and Development (OECD), 2008).

The Accra Agenda was signed approximately two-and-a-half years after the Paris Declaration, on 4 September 2008 in Accra, Ghana. Like the Paris Declaration, the Accra Agenda was ratified by health ministers from many countries (including Namibia); heads of bilateral and multilateral development, such as the WHO; by GHIs such as the Global Fund and PEPFAR; by civil society organisations, and by private foundations. The Accra Agenda is a direct follow-up to the Paris Declaration (Organisation for Economic Co-operation and Development (OECD), 2008). Table 1.3 below shows the six main objectives of the Paris

Declaration alongside the three most important goals of the Accra Agenda.

Table 1-3 Objectives of the Paris Agenda

Paris Declaration on AID Effectiveness	Accra Agenda
<ol style="list-style-type: none"> 1. Strengthen partner country national development strategies and associated frameworks 2. Increase alignment of aid with partner countries' priorities, systems and procedures for helping strengthen their capacities 3. Enhance donor and partner country respective accountability to citizens and parliaments for their development strategies, policies and performance 4. Eliminate duplication and rationalise donor activities to make them as cost-effective as possible 5. Reform and simplify donor procedures to encourage collaborative behaviour and progressive alignment with country priorities, systems, and procedures 6. Define measures and standards of performance and accountability of partner country health systems in public financial management, and fiduciary safeguards assessments in line with existing good practices 	<ol style="list-style-type: none"> 1. Improve country ownership so that developing country governments can take stronger leadership of development strategies and better engage their parliaments and citizens. This requires donors to invest in human resources and institutions, and better use existing country aid flow systems (article, 8). 2. Build more effective and inclusive partnerships through better management and coordination mechanisms (Article, 9). 3. Achieve development results and openly account for them through demonstrating that development actions translate into positive impacts in people's lives (Article, 10).

Achievement of the Paris Agenda objectives calls for country ownership of operational strategies with partners. It in particular calls for the alignment of donor practices with country systems and procedures. This quest for alignment is best represented by Objective 2 of the Paris Declaration, which aims to “Increase alignment of aid partner countries’ priorities, systems and procedures for helping strengthen their capacities” (Organisation for Economic Co-operation and Development (OECD), 2008, sec. 1). Objective 2 recognises that countries have their own approaches to addressing health problems and would be more effective in addressing health concerns if donors contributed to strengthening rather than undermining existing plans.

The Accra Agenda particularly emphasises the importance of accelerating progress in three main areas (P.15):

1. Country ownership, so that developing country governments can take stronger leadership of development strategies and better engage their parliaments and citizens. This requires donors to invest in human resources and institutions, and better use existing country aid flow systems (article, 8).
2. Build more effective and inclusive partnerships through better management and coordination mechanisms (Article, 9).
3. Achieve development results and openly account for them through demonstrating that development actions translate into positive impacts in people’s lives (Article, 10).

The Paris Agenda represents a recognition in the international development community that external funding for health issues does not adequately promote country ownership and institutional autonomy.

Based on the articulation of country ownership in the Paris Agenda,

Whitfield and Fraser (2009) define ownership as the "degree of control recipient governments can secure over implemented policy (Whitfield and Fraser, 2009a, p.4).

Whitfield and Fraser (2009) argue that rather than getting aid givers to reform themselves, the international aid community (as represented by international policy agreements on aid effectiveness), places the onus on recipient governments to "take ownership" of aid activities:

Contemporary donor promotion of ownership is partly a discursive response to criticisms of dominant funding practices, especially the use of conditionality. Donors deploy the term partly because it implies recognition of, and apparent accommodation with, their critics' position. By claiming that they will no longer impose policies on unwilling recipients, donors are searching for a renewed legitimacy of their activities (p.5)."

As perceived by Whitfield and Fraser (2009) agreements such as the Paris Agenda are merely symbolic and superficial calls to country ownership that do not reflect an actual commitment by international funders to encourage country ownership. Banati and Moatti (2008) and Buiter (2007), similarly criticise the Paris Declaration and Accra Agenda for being empty symbolic gestures because they do not provide clear guidelines on concepts such as sustainability and country ownership.

Buiter (2007) expressly criticises the use of the word "country ownership" and dismisses it as a vague and ill-defined concept that has become a "pernicious example of politically correct international financial institution speak (p.647)". As perceived by Buiter (2007), it is easy

enough for GHIs to claim that they seek to encourage and align with the structures and priorities of country ownership if there are no clear indicators to hold them accountable if they fail to live up to the principles of country ownership.

The criticisms around country ownership as defined through the Paris Agenda reflect the fact that aid from external funders such as GHIs does not only go to a country as a whole, but also to particular institutions within the country. Thus the concept of ownership needs to be practically broken down into the overall country context as well as its implications for the individual agency. Critics of the Paris Agenda, such as Buiter (2007), however, do not provide a clear alternative as to how the concept of country ownership can still be meaningful. Rather than just criticising country ownership as defined by others, De Valk (2009) seeks to offer a working definition of the concept, particularly for organisations within a recipient country that engage with external funders.

According to De Valk (2009), the idea of ownership of a project or policy by an organisation can be loosely understood as a concept that seeks to capture the degree of responsibility that the organisation has and shows for the design, the planning and implementation of the project or policy and for sustaining the results. De Valk (2009) argues that ownership must be analysed not just through its intentions and priorities but primarily through its practice (De Valk, 2009). De Valk (2009) defines organisational ownership as meaning the ability of an organisation to

influence or control project processes and outcomes, in addition to being able to use the project output. Thus at an agency level, the concept of ownership then becomes interchangeable with the idea of the degree of autonomy that an organisation can exercise in the presence of external support. Analysing the extent of autonomy in making decisions on specific (elements of) projects then has potential to shed light on whether project implementation is sustained and in which manner (p.30).

The extent of autonomy that recipients experience in their engagement with external donors has implications for how their operational capacity is affected both by the presence and departure of funders. Thus the extent to which GHI funding increased health systems capacity is one of the key issues that is examined by this thesis in its consideration of GHI influence on country ownership and Ministry of Health autonomy in Namibia. This concept of organisational ownership can then be defined as autonomy to separate it from the broader concept of country ownership. This thesis engages with the idea of country ownership as defined by Objective 2 of the Paris Declaration and the broken down through the Accra Agenda. With a focus on the notion of alignment as reflected in the agenda, the thesis examines the extent to which the practices of the Global Fund and PEPFAR in Namibia facilitated the autonomy of the Ministry of Health.

1.5 Namibia's Political History

The country known as Namibia today was not a political colony until German officially sought to govern it in 1890, and named the country German South West Africa (Cliffe, 1994; Kaela, 1996). After the First World War ended in 1919, Germany lost almost all of its colonial territories. Namibia was put under the patronage of the United Kingdom, then of South Africa, through the League of Nations in 1919. Under the mandate system, South West Africa was deemed as being unable to self-govern and therefore needing political and economic support to eventually achieve independence (Dugard et al., 1974; Kaela, 1996). The British Government (through South Africa) was supposed to prepare the South West Africa for “self-determination” and “not profit from its administration rights” over the country (Dugard et al., 1974; Kaela, 1996). However, following its independence from Britain in 1934, the South African government at the time annexed Namibia and refused to submit reports to the League of Nations (Dugard et al., 1974; Kaela, 1996).

When the United Nations (UN) replaced the League of Nations in 1946, it also took over the former multilateral organisation's ambitions and responsibilities of transitioning former colonies to independence (Davis et al., 1966; Dugard et al., 1974). As part of this function, the UN General Assembly used its first ever session to take up the resolution to

place South West Africa under UN Trusteeship. The South African Government, however, refused to acknowledge the UN as the official successor of the League of Nations and refused to comply with the resolution (Kaela, 1996; Kozonguizi, 1966). This first decision marked the start of an international diplomatic struggle for Namibian independence that would last for more than 40 years.

Namibia's path to independence was decided in 1976 through UN Resolution 385 (also known as the Namibia Peace Plan), which called for free and fair elections in the country under the supervision of the UN (Kaela, 1996; Kozonguizi, 1966). As part of the Namibia Peace Plan, the UN General Assembly also established the United Nations Transition Assistance Group (UNTAG) for Namibia (Cliffe, 1994; Hartmann, 2009). The UN directed UNTAG to administratively prepare the country for independence within one year (Hartmann, 2009). Namibia officially became an independent member of the UN on the 21st of March 1990.

The political foundations of an independent Namibia are a reflection of the country's history with the UN. For example, through Resolution 283 in 1970, the UN set up a fund and appointed a Commissioner for Namibia in 1974 (Cliffe, 1994). One of the Commissioner's first tasks was to establish the Namibia Research Institute in Lusaka, Zambia. The role of the Institute was to develop economic, social and political policies for independent Namibia. The main components of the Constitution that the Republic of Namibia adopted at

independence in 1990 were drawn up in 1982 at the Lusaka Institute, in a document titled Principles Concerning the Constituent Assembly of an Independent Namibia (S/15287) (Cliffe, 1994).

The Constitution defines Namibia as a democratic unitary system of government, governed by separate and independent legislative, executive and judiciary branches. The Constitution also declares fundamental human rights and protection of civil liberties for the Namibian people. The Namibian Constitution is one of the most progressive in the world due to its extensive protection of human rights (Hartmann, 2009). Since independence, the country has also frequently been ranked by various global indices as one of the best-governed countries in Africa (OECD et al., 2013). On the 21st of March 2015, Namibia celebrated its 25th year of independence, which marked the transfer of power to the third democratically elected president.

1.6 HIV and AIDS in Namibia: Research Relevance

This thesis engages with the concept of country ownership in the engagement between international donors to HIV and AIDS and recipient health systems. It seeks to understand the extent to which the Namibian Ministry of Health was able to exercise ownership of the Namibian health sector in the presence of Global Fund and PEPFAR funding. In seeking to understand the impact of the rise and fall of Global Fund and PEPFAR

funding to Namibia, this thesis evaluates the ways in which the practices of the two GHIs initially encourage country ownership and institutional autonomy. The thesis then examines the ways in which the Namibian policy environment was able to mitigate the potentially negative impacts of the two GHIs.

The Namibian context is relevant and informative for several reasons. Since the country's independence in 1990, communicable diseases, mainly HIV/AIDS, Tuberculosis, and Malaria have accounted for the greatest share of illness burden in Namibia (MoHSS, 2010a; Zere et al., 2006). HIV and AIDS, in particular, has had a devastating effect on the population. The first reported incident of AIDS in Namibia was in 1986 (El Obeid, 2001; Slotten, 1995). Between 1992 and 2000, overall rates of HIV infection rose from 4% to 22.3% (MoHSS, 2008a). Between 1995 and 2000, approximately one out of every five deaths in Namibia were due to AIDS (El Obeid, 2001; MoHSS, 2005). Table 1.4 shows the top 10 causes of death in Namibia in 2006, as reported by the country's Ministry of Health.

Table 1-4 Top 10 Causes of Death in Namibia 2006: (MoHSS, 2008a)

Cause of Death	Number of Deaths
HIV/AIDS	3,735
Gastroenteritis (Diarrhoea)	2,495
Pulmonary TB	1,961
Pneumonia	1,623

TB	951
Respiratory Disease	755
Anaemia	485
Heart Failure	473
Malnutrition	265
Hypertension	256

The highest HIV prevalence rates in Namibia have historically been among young people and women (European Economic Fund, 2008; McCourt and Awases, 2007; National Planning Commission, Office of the President, 2008). In 2000, about 25% of HIV infections were among people aged between 25 and 29 (MoHSS, 2010a). The HIV prevalence rate has also been historically higher among women when compared to men of the same age (MoHSS, 2008a).

The Namibian government was already providing a limited amount of HIV treatment before it received funding from the Global Fund and PEPFAR (Farahani et al., 2014; Hecht et al., 2010; Schneider et al., 2006). In 2002, the Namibian Government introduced free prevention of mother-to-child transmission (PMCT) at two hospitals. The Government followed on with free antiretroviral therapy (ART) in 2003 at three hospitals. Through its financial contributions and support from the Global Fund and PEPFAR, the Namibian Government undertook a rapid scale-up of HIV treatment (MoHSS and ICF Macro, 2010; PEPFAR

Namibia, 2012). By 2010, access to free HIV and AIDS treatment had been scaled up to all 34 district hospitals and 250 health facilities and clinics (MoHSS and ICF Macro, 2010). As a result, the ART coverage rate in Namibia rose from 3% in 2003 to 90% by 2010 (MoHSS, 2010b).

The Namibian Government and others have credited some of the rapid increases in the provision of HIV and AIDS services to the financial contributions of Global Fund and PEPFAR (Presidential Commission of Inquiry: MoHSS, 2013; United States Department of State and the Broadcasting Board of Governors Office of Inspector General, 2010a). The increased level of participation by the Global Fund and PEPFAR in Namibia led to increased financial allocations to addressing HIV and AIDS in the country (Red Cross Society, 2010; WHO Africa Region, 2010; World Bank, 2009; Ministry of Health, 2010; Ministry of Health, 2008) (See Appendix 1).

Funding from the Global Fund and PEPFAR also led to a general increase in the number of civil society and non-government agencies funded to implement health intervention. Between 2001/02 and 2006/07, the share of total health funds controlled by the Government fell from 57% to 43%, while the share controlled by NGOs rose from 1.6% to 16% during the same period. In Namibia for fiscal years 2008/09, HIV and AIDS consumed 28.5% of total health expenditures; 45% of those funds came from public funds, while 51% came mainly from the Global Fund and PEPFAR (Ministry of Health, 2010). Funding from the Global Fund

and PEPFAR increased Namibia's overall health budget and shifted the proportions of the budget that were contributed and managed by the Namibian Government (MoHSS and Health Systems 20/20, 2008).

Globally, a disproportionate amount of Global Fund and PEPFAR funding initially went to countries that are ranked as low income according to global economic indicators (Druce and Dickinson, 2008a; Hecht et al., 2010). Immediately after independence, Namibia received substantial financial assistance from international donors, primarily because of its classification as a low-income country (Cliffe, 1994). By 1999, Namibia had moved from being a low-income country to a middle-income country (El Obeid, 2001). The country's increased economic ranking led to the withdrawal of many donors. Funders withdrew under the argument that other nations had a greater financial need for their support (Ministry of Health, 2003; Ministry of Health, 2006; Ministry of Health, 2010; Office of the President of Namibia, 2009; WHO Africa Region, 2010).

Funding from the Global Fund and PEPFAR increased donor support for health in Namibia. However, in the aftermath of the changes in the financing priorities of the Global Fund and PEPFAR, Namibia was one of the countries expected to increase domestic funding for HIV and AIDS. Namibia was one of the countries directly impacted by the new focus of the Global Fund and PEPFAR of also making funding decisions based on ability to pay, rather than primarily based on population health

need (Department Of State. The Office of Electronic Information, 2009; The Global Fund, 2013a). At the arrival of the two GHIs in the country, the Namibian health sector, however, suffered from various health systems deficits such as those relating to inadequate human resources capacity (Ministry of Health and Health Systems 20/20, 2008; Ministry of Health, 2010; USAID, 2010; WHO Africa Region, 2010; UNAIDS, 2008). Thus, despite the HIV and AIDS epidemic, there was a need to strengthen the Namibian Government's overall health system.

1.7 Structure of the Thesis

Chapter one has introduced the concepts of country ownership and autonomy, within the context of the origins and changing objectives of the Global Fund and PEPFAER. This thesis examines the extent to which the structures and processes, which have defined the relationship between the Ministry of Health and the two GHIs over the years covered by the analysis, can be said to have positioned the Ministry to sustain the efforts that arose from the relationships. The thesis posits that the success of GHIs cannot only be measured based on their impacts at the height of funding but the potential for that impact to be sustainable once GHI funding has ceased.

This thesis frames a wider discussion on country ownership within a larger discussion of the health system implications of GHIs at country-

level. The health systems implications are the focus of chapter two, which uses the framing of country ownership and organisational autonomy presented in this chapter to examine the literature on the impacts of the Global Fund and PEPFAR at country-level.

Chapter two will elaborate on how the thesis seeks to understand GHIs through their interactions with particular components of the health systems of recipient countries. The next chapter will also reflect on how the existing literature has sought to understand the extent to which the Global Fund and PEPFAR have facilitated or hindered country ownership. With a focus on the themes of financial flows; human resources management; and the engagement between governments and CSOs, chapter two also reflects on the health system implications of known GHI practices. The chapter concludes with an explanation of the research contribution of this thesis.

Chapter three reflects on the research design that underlies the data gathering and analysis for this thesis. This chapter discusses the research methods, with a focus on the methodology of a qualitative case study. It also discusses some of the ethical and practical issues that arose from the research. The chapter concludes by reflecting on the implications of subjectivity in qualitative research.

Chapter four lays out the Namibian context regarding the characteristics of the public health system. In particular, it highlights the ways in which Namibia has already defined its public health system

environment for addressing HIV and AIDS. It also provides a descriptive overview of the involvement of PEPFAR and the Global Fund in the Namibian health system. It provides background on Namibia's relationship with the Global Fund and PEPFAR regarding the agencies involved in the relationship, and the general known implications of their support at the time of data collection for the thesis.

Chapter five evaluates financial flows in the Ministry of Health's engagement with the Global Fund and PEPFAR. In particular, Chapter five examines the initial practices for disbursements and financial management. The chapter then assesses the implications of these initial structures and processes for the Ministry of Health when it faced a decline in funding from the Global Fund and PEPFAR.

Chapter six examines the procedures and structures for human resources management in the Ministry of Health's relationship with the two GHIs. It examines the administrative structures and procedures that were adopted by the Ministry of Health when it first started to get support from the Global Fund and PEPFAR. The chapter primarily reflects on the structures and processes for recruiting and managing staff to work on interventions funded by the two initiatives.

Chapter seven examines the Ministry of Health's relationship with the Global Fund in the context of the Namibian Government's engagement with indigenous civil society organisations also seeking to address HIV and AIDS in the country. Similar to the first two thematic

chapters, chapter seven primarily describes and evaluates the ways in which the changing levels of Global Fund support to Namibia influenced the Ministry of Health's ownership in the coordination and engagement of HIV and AIDS civil society organisations.

Chapter eight is the main discussion. It examines the ways in which the findings chapters contribute to understanding the country-specific health system interactions of the Global Fund and PEPFAR. Continuing the theme of the rise and decline of GHI funding, the chapter reflects on the health system lessons to be learned given the ways in which the Global Fund and PEPFAR influenced country ownership in Namibia.

Chapter nine concludes the thesis by presenting an overall summary of the thesis findings and arguments.

2. HIV and AIDS GHI: Country Ownership and Health Systems

2.1 Introduction

As explained in Chapter One, the rise of the Global Fund and PEPFAR is associated with the year 2000 and the ambitions of the Millennium Development Goals (MDGs). Through the MDGs, the international development community had identified HIV and AIDS as one of the key health issues to be tackled with substantial funding (Komatsu, 2007; Richard et al., 2011; The United Nations, 2014). Fitting within this larger narrative, both GHIs defined themselves as having the objectives to facilitate the rapid increase of resources to HIV and AIDS. The Global Fund and PEPFAR fundamentally altered the amount of financial resources available to address HIV and AIDS at a global level (Grundfest Schoepf, 2004; McCoy et al., 2009; Richard et al., 2011; Shiffman, 2009; WHO Maximizing Positive Synergies Collaborative Group, 2009).

The vast amounts of funding provided by the two initiatives might have distorted the health system priorities of recipient countries (Amaya et al., 2014; Atun and Kazatchkine, 2009; Biesma et al., 2012; Cailhol et al., 2013; Mwisongo and Nabyonga-Orem, 2016). In some instances, the Global Fund and PEPFAR were criticised for overemphasising immediate measures of success at the expense of country ownership and wider

health system improvements (Banteyerga et al., 2006; Chima and Homedes, 2016; Collins and Beyrer, 2013; Hanefeld, 2010). This thesis is concerned with the impacts of the two GHIs on country ownership and autonomy, and their associated implications for health systems strengthening and its sustainability in the aftermath of GHI support.

By their initially defined health objectives, chapter one introduces the Global Fund and PEPFAR within global discussions on country ownership in the engagement between government recipients and external donors to the health sector. The examination of national ownership, in particular, draws on the Paris Agenda for Aid Effectiveness, which is an international commitment aimed at promoting country ownership, and to which the Global Fund, PEPFAR, and the Namibian Government are all signatories (Organisation for Economic Co-operation and Development (OECD), 2008).

The purpose of this chapter is to reflect on prior literature which has sought to elucidate the country-specific impacts of the Global Fund and PEPFAR. It examines the extent to the existing research on the effects of HIV and AIDS GHI impacts on health systems has taken into account the issue of recipient country ownership and autonomy. The chapter first introduces the perceived main building blocks of health systems as defined by the World Health Organization (WHO) (World Health Organization, 2010, 2007). Using the WHO's articulation as a starting point, the chapter examines the ways in which other research

has positioned the potential health systems impacts of the Global Fund and PEPFAR. With a focus on the government's role in health systems, the chapter then examines the themes of financial flows; human resources management; and civil society engagement. It examines the extent to which GHIs have been found to have impacted country ownership and autonomy concerning these three themes.

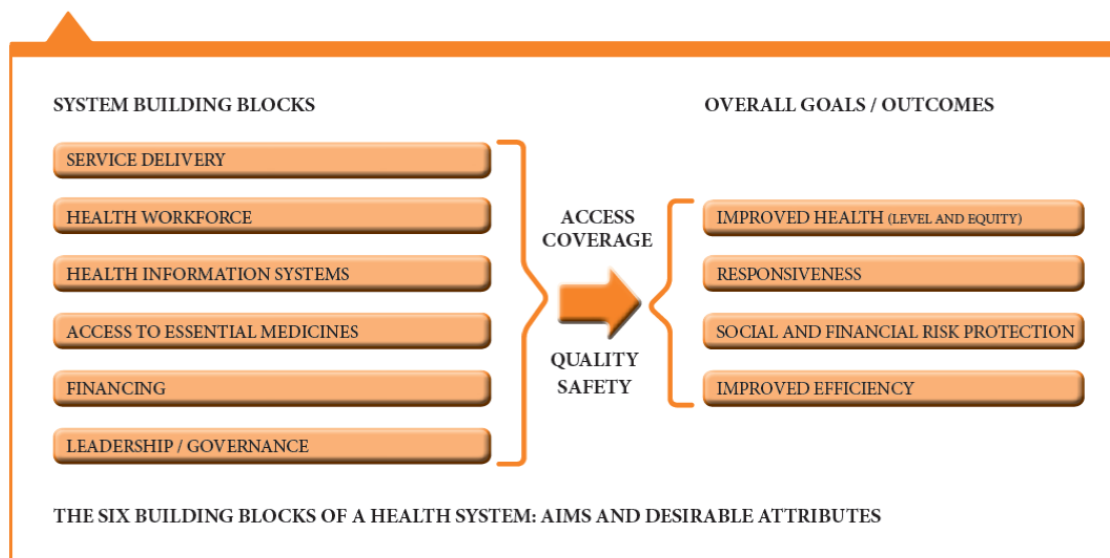
The chapter then defines the research contributions of this thesis. It concludes with a reflection on the thesis' contributions regarding a qualitative study, which takes the priorities of the recipient as a starting point. The thesis also makes a research contribution by taking into account what might happen when the country faces a scale-down of financial support from GHIs. The literature reviewed mainly focuses on research that has sought to examine the country-level impacts of the Global Fund and PEPFAR.

2.2 Health Systems and Country Ownership: Global Fund and PEPFAR

The WHO defines health systems as "all actors and institutions in a country whose primary intent is to improve or maintain health in that country (World Health Organization, 2007)". The WHO Framework for health systems action defines health systems as being made up of six discrete building blocks or health system functions. These are 1) service delivery; 2) health workforce; 3) information; 4) medical products,

vaccines and technologies; 5) financing; and 6) leadership and governance (stewardship) (World Health Organization, 2007, p. v).

Figure 2-1 World Health Organisation Health System Framework: (WHO, 2007, p.V)



The WHO's framework argues that when each of these six building blocks is strengthened, then this will lead to increases in four areas: access, coverage, quality and safety for users within a health system. An improvement in these four areas is then supposedly meant lead to improved health outcomes; responsiveness of the health system to population needs; social and financial risk protection for both users and service providers; and improved efficiency (World Health Organization, 2010, 2007). The WHO has constructed health systems and their sub-components as easily identifiable and thus fixable when found to be inadequate (WHO Maximising Positive Synergies Collaborative Group, 2009).

Studies on the health systems impacts of the Global Fund and PEPFAR, frequently use the World Health Organisation (WHO) definition of the essential building blocks of a health system (Atun and Kazatchkine, 2009; Bennett and Fairbank, 2003; Biesma et al., 2009; Chima and Homedes, 2016; Kelly and Birdsall, 2010; Rasschaert et al., 2011; WHO Maximizing Positive Synergies Collaborative Group, 2009). Using the WHO definition of health systems, Bennett and Fairbank (2003) were some of the first researchers who sought to understand and predict the country-specific health systems impact of the Global Fund. They present an analytical approach, which aims to evaluate the Global Fund's broader effects on national health care systems (Bennett and Fairbank, 2003). They base their approach on the premise that the design and implementation processes of GHI interventions will have a direct impact on targeted diseases as well as broader health care system regarding equity, efficiency, access, quality, and sustainability (Bennett and Fairbank, 2003).

Bennett and Fairbank (2003) propose that by reviewing the design, selection and implementation processes of the Global Fund, they can assess the effect on national level stewardship and policy, resource development, financing and service delivery functions. Their strategy for analysis then proposes that the country health system might mediate the potentially negative impacts of the Global Fund by monitoring and evaluating the GHI's effects on four main areas: policy environment,

public/private mix, human resources, and pharmaceutical and commodities (Bennett and Fairbank, 2003).

For Bennett and Fairbank (2003) the issue of country ownership and organisational autonomy are included within the health system function of stewardship and policy. Their approach is, however, more focused on evaluating the impact of GHIs alone, rather than how they might intersect with existing country processes and procedures. It does not leave much room to assess how the governments of recipient countries might, in turn, be trying to manage their relationship with GHIs. They do recognise that the system-wide effects that of the Global Fund that will occur in-country will be affected by the country context in terms macroeconomic, political and development assistance context; and government and health system capacity; and service delivery structures (Bennett and Fairbank, 2003).

Biesma et al. (2009) reviewed country level evidence on the impacts of the Global Fund, PEPFAR and the World Bank Multi-country AIDS Program (MAP). They used Bennett and Fairbank's framework as a starting point to understanding the impact of the Global Fund and PEPFAR, by drawing on more than 30 country-specific and cross country reports based on fieldwork conducted between 2002 and 2007. All of the studies they evaluated were descriptive cross-sectional studies, with most using data collected at a national level. They present a framework, which frames the intersection between GHIs and country health systems

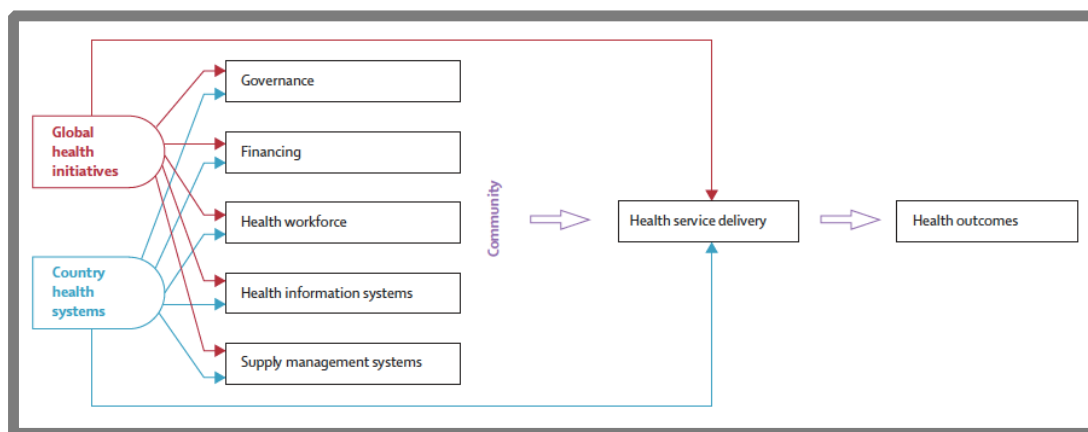
through a focus on health sector policy development and policy implementation.

Biesma et al. (2009) define "policy development" as reflecting "global concerns around country ownership, harmonisation and alignment of GHIs with national priorities and policies, as expressed in the Paris Declaration on Aid Effectiveness (p.241)". For policy implementation, Biesma et al. (2009) identified four cross-cutting health system themes: 1) Coordination and planning; 2) Stakeholder engagement; 3) Monitoring and Evaluation; and 4) Human resources. Under the four cross-cutting themes of implementation, their study first presents and interprets the adverse effects of GHIs, and then shows and explains the benefits and lessons learned by GHIs across the period of study.

The main negative impacts of HIV and AIDS GHIs identified by Biesma et al. (2009) was the perceived distortion of recipient national priorities. They criticise GHIs for distracting national governments from strengthening health systems through the establishment of free-standing planning, management and monitoring and evaluation systems. Biesma et al. (2009) propose that country health systems can mitigate the potentially negative impacts of GHIs through the health policy process. Their framework suggests that alignment of GHIs with national priorities can be assessed for the whole health system at the policy development and policy implementation stages.

In 2009, the WHO commissioned a broad group of stakeholders, which it called the Maximising Positive Synergies Collaborative Group, to carry out a review and analysis of existing data on the interplay between GHIs (including Global Fund and PEPFAR) and country health systems (WHO Maximising Positive Synergies Collaborative Group, 2009). Also building on the WHO's definition of health systems as the well as the work done by Bennett and Fairbank (2003) and Biesma et al. (2009), the Maximising Positive Synergies Group evaluated the intersection of GHIs with country health systems by focusing on five main areas of engagement. These five areas are information systems, finance, governance, workforce, and supply management systems (WHO Maximizing Positive Synergies Collaborative Group, 2009) (see Figure 2.2).

Figure 2-2 WHO Maximising Positive Synergies Framework for GHI Interactions with Country Health Systems (2009)



The Maximising Positive Synergies Group constructs initiatives such as the Global Fund and PEPFAR as interacting with health systems, to influence health systems functions. Building on the WHO's health systems interactions among various stakeholders, the Group constructed GHIs and country health systems as having both an independent and combined impact on health services delivery and other resultant outcomes at identifiable points and sub-points within a health system (WHO Maximizing Positive Synergies Collaborative Group, 2009):

When they arrive in a country, GHIs not only interact with the various actors, but they sometimes interact with them at different points in time as part of a particular sub-system function. GHIs insert themselves into country health systems and have the potential to have a significant impact on the operations of any of the sub-systems (p.2143).

Relationships between initiatives such as the Global Fund and PEPFAR, and the governments that receive their support, however, have the potential to create tensions around issues related to dual accountability. These initiatives have accountability to meet their stated goals, which are often short-term in nature (Car et al., 2012; Collins et al., 2008; Harsh et al., 2010; Sidibe et al., 2006). They also have accountability to meet the demands and expectations of those that fund them. By only evaluating donor-recipient relationships under a supposedly objective health systems lens, the assumption is that funders have equal power to decide on the governance of recipient country health systems.

The Maximising Positive Synergies Collaborative Group was made up of more than 50 individuals from all over the world who represented academia, governments, civil society, and the private sector (WHO Maximising Positive Synergies, 2009). The convening of this group reflects the salient position of GHIs in the global health arena. As a political undertaking, the Maximising Positive Synergies exercise and its subsequent findings reflect the global recognition that GHIs are likely to have a significant impact on national health systems beyond their stated disease-specific objectives.

The Maximising Positive Synergies, however, belies an assumption that GHIs are unproblematic as a model for achieving global health goals and it, therefore, takes a very uncritical view to their existence. GHIs are often unquestioningly endowed with legitimacy because they are seen as providing welfare-enhancing interventions and are automatically assumed to reflect the objectives and priorities of recipient countries (Buse and Harmer, 2004). The Group also places emphasis on determining whether the goals of GHIs are met and treats the country context as a secondary component of the analysis. The Group's criterion for a successful interaction between GHIs and country health systems is based on determining whether the GHIs have had no adverse impact on the health system as they attempt to reach their goals. This approach does not allow for a balanced inquiry of whether or not GHI interventions are in line with the priorities of a given country's health system.

Even as the study is titled "An assessment of interactions between global health initiatives and country health systems", it mainly focuses on determining whether GHIs can meet their stated objectives given the various country contexts. Based on the title, a more balanced approach to their analysis would have also been to assess whether country health systems are still able to meet their stated objectives in the presence of GHIs. The approach taken by the Maximising Positive Synergies Group is in many ways reflective of other research that has explored the interactions between GHIs and country health systems. This thesis takes a critical view in its analysis of GHIs impact on country health systems. For this thesis, the health system themes of financial flows, human resources and civil society engagement as associated with the Global Fund and PEPFAR are particularly relevant. The next three sections reflect on the how the two HIV and AIDS GHIs have influenced country ownership and organisational autonomy concerning these three themes.

2.2.1 Financial Flows and Management

Bennett and Fairbank (2003) predicted that the Global Fund's initially stated intentions to fund countries based on the proven performance of the grants would lead to the development of financial monitoring and transfer systems, which were parallel to those that recipients already had in place (Bennett and Fairbank, 2003). These predictions appear to have been realised for both the Global Fund and

PEPFAR (Brugha et al., 2010; Hanefeld et al., 2007; Mtonya et al., 2005; Oomman et al., 2008). Advisors and consultants specifically associated with funders are a frequent feature of donor support to global health initiatives and other international development projects (Easterly, 2008; Harsh et al., 2010; Riddell, 2007). Short-term grant management structure are established to improve the ability of beneficiaries to meet the reporting requirements of the Global Fund and PEPFAR. Money from the Global Fund and PEPFAR has then been used to pay staff to manage and oversee the new structures and processes (Biesma et al., 2012a; Drager et al., 2006; Oomman et al., 2008).

In 2007, Oomman et al. (2008) examined the flow of financial resources from PEPFAR, Global Fund, the World Bank's Multi-Country AIDS Program (MAP) in Mozambique, Uganda and Zambia. Their analysis focused on donors' policies and practices and their resulting interactions with national governments and other stakeholders in supporting a national HIV and AIDS response. With the Paris Declaration as a starting point, Oomman et al. (2008) defined the goal of their research as seeking to make recommendations on how the movement of funds could be made more effective (Oomman et al., 2008). They evaluate how each GHI worked with governments; built local capacity; kept funding flexible; selected recipients; made money move; collected and shared data.

In Mozambique, Uganda and Zambia, the national governments were the primary providers of HIV and AIDS service before the arrival of funding from the two GHIs. PEPFAR did not channel most of the funding through government systems. Government organisations had capacity constraints concerning their ability to quickly meet pre-defined PEPFAR health targets. Thus, in all three countries, Oomman et al. (2008) conclude that PEPFAR funding was allocated mainly based on requirements set by the U.S Congress for the treatment, prevention, care of patients and vulnerable orphans (Oomman et al., 2008).

In comparison to the Global Fund, PEPFAR structures and procedures for financial flows requirements have been found to be both more inflexible and more uniform across different countries (Fan et al., 2013; Hanefeld, 2010; Oomman et al., 2008). The need to meet U.S Government legislatively-mandated targets on prevention, treatment and care drove the initial operations of PEPFAR (108th USA Congress, 2003). This emphasis on specific targets was found to lead PEPFAR to prioritise speed and efficiency over factors like improving the sustainability capacity of recipients. When PEPFAR money first arrived in many countries, it was primarily channelled by non-government, even when governments were the primary providers of HIV and AIDS services. PEPFAR administrators viewed recipients as lacking the capacity to quickly translate funding into its pre-defined health targets within the

five-year period of the GHI's two funding authorisations (Hanefeld, 2010; Oomman et al., 2008).

Even when governments are the primary funders and providers of existing health services, their involvement in the oversight of PEPFAR programs was initially found to be limited. U.S Government staff, both in-country and at headquarters in the USA, were often the ones that coordinated the activities of various PEPFAR recipients (Oomman et al., 2008). In Uganda, CDC was known to monitor the activities of recipients actively and require them to frequently justify their actions (Oomman et al., 2008). In Uganda, Mozambique and Zambia, there were criticisms that PEPFAR did not make the government a real partner. Research in these three countries showed that financial and performance data were not routinely made available to public officials at crucial times such as during the development of their country's annual budgets (Oomman et al., 2008).

In contrast to PEPFAR, Oomman et al. (2008) credited the Global Fund for choosing recipients in a highly flexible way both within and between countries. As a result, they argue, funding from the Global Fund went to recipients whose capacity might not have been viewed as adequate by PEPFAR (Oomman et al. 2008). In the three study countries, Global Fund support mainly went to government agencies. In Uganda and Mozambique, all funding from the Global Fund went through public sector recipients that were already addressing HIV and AIDS. Oomman

et al. (2008) perceived the Global Fund as being more aligned with country ownership because it primarily funded agencies that were the primary health implementers through national public legislations.

The perceived tendency for PEPFAR to bypass government systems, even when government facilities were the main providers of health services, is also reflected in findings from South Africa and Zambia (Hanefeld, 2010). In the two countries, Hanefeld (2010) found that PEPFAR allocated a large proportion funding to agencies with North American connections. In comparison to PEPFAR, Hanefeld (2010) found that Global Fund supported activities were perceived as more closely aligned with the objectives of recipient national Governments. Reflecting on the two initiatives and their differing intentions towards promoting country ownership in South Africa and Zambia, Hanefeld (2010, p. 97) noted the following:

Research findings indicated PEPFAR mainly operates through a structure separate from the state, including its support for public sector treatment programmes, which raises questions of country ownership of activities and programmes. Whereas Global Fund funding for treatment has largely been for the assistance of the government treatment programmes (Hanefeld, 2010, p. 97).

In South Africa and Zambia, respondents interviewed for the research noted that not only was PEPFAR funding channelled to non-government agencies, but government officials had limited input in planning for how the funding was used once it arrived in the countries (Hanefeld, 2010, p. 97). As Hanefeld (2010) noted for PEPFAR, it is easy

to conflate the amount of donor funding countries receive because the money goes towards staff whose primary goal is to monitor donor funding (Hanefeld, 2010, p. 98). Hanefeld (2010) also questions whether the PEPFAR initiatives can be considered to have built the capacity of a recipient country when its funding was primarily used to temporary fund agencies and individuals with a link to the U.S Government.

The Global Fund has been positioned as distinct due to its stated intentions to not establish in-country offices (Hanefeld, 2010; Riddell, 2007). Regarding financial flows and management, research has frequently found that the Global Fund has not been as flexible as its guidelines would first indicate. From the onset of its operations, the Global Fund often mandated the specific processes for which it required its funding to be channelled and managed (Biesma et al., 2012; Carlson et al., 2004; Mtonya et al., 2005). A standard feature of the initial operations of Global Fund grants has been a country-specific Program Management Unit (PMU).

Oliveira Cruz and McPake (2011) found that both the Global Fund and PEPFAR opted to create parallel systems of financial management in Uganda. Their structures and processes for management did not contribute to the health Sector Wide Approach (SWAp), a mechanism which would have earmarked their funds for the health (Oliveira Cruz and McPake, 2011). Under the SWAp strategy, the Ugandan Government had set a limit for how much of the pooled money could go towards each

ministry (Carlson et al., 2004). Oliveira Cruz and McPake (2011) found that the Global Fund in Uganda used a PMU within the Ministry of Health (MoH), which had its own monitoring tools and a parallel system for managing its grant (Oliveira Cruz and McPake, 2011).

Biesma et al. (2012) found that Lesotho was another country that was required to establish a PMU as a pre-condition to receiving its first Global Fund grant. In Lesotho, the Ministry of Finance was the Primary Recipient (PR) of the Global Fund grant, but the Ministry of Health was the principal implementer of the GHI-supported interventions (Biesma et al. 2012). Biesma et al. (2012) argue that the establishment of a coordination unit unique to the Global Fund created connections and new ways of working with the Ministry of Finance and the Ministry of Health, and across to other government and non-governmental organisations. The PMU was viewed as operating in a non-constrained way when compared to the traditional functions of the Ministry of Health (Biesma et al., 2012).

2.2.2 Human Resources Management

In the early 2000s, before the establishment of the Global Fund and PEPFAR, inadequate human resources capacity was perceived as hindering the rapid scale-up of HIV and AIDS in many countries (Banteyerga et al., 2006; Biesma et al., 2012; Hanefeld and Musheke, 2009; Oomman et al., 2008). A significant portion of Global Fund and

PEPFAR financial resources therefore initially went towards the recruitment and training of health workers to provide HIV and AIDS services. Consequently, both GHIs extended the human resources capacity in the countries that initially received grants (Biesma et al., 2012; Dodd and Lane, 2010; Hanefeld and Musheke, 2009; Oomman et al., 2008; WHO Maximising Positive Synergies Collaborative Group, 2009).

In their review of studies on the intersections of GHIs and specific country systems, Biesma et al. (2009) found that a shortage of trained health workers was a dominant barrier to health system performance in several countries before the arrival of Global Fund and PEPFAR resources. These health worker inadequacies were in turn viewed as initially hindering GHI efforts to scale up HIV and AIDS services. The studies, however, regularly revealed that the Global Fund and PEPFAR often developed human resources capacity specifically for only the interventions that they funded (Biesma et al., 2009). Biesma et al. (2009) found that many of the initial studies that sought to understand the human resources impacts of GHIs focused on issues such as worker motivation, workload and incentives, as well as training, which are all related to direct-service delivery.

GHIs have been criticised for creating parallel human resources structures, which then lead to the pilfering of human resources from the structures that already have a limited capacity. Thus previous research

focused on the symptoms of different working conditions rather than the causes of the working conditions. There is limited discussion of the ways in which the GHIs went about creating different working conditions for health workers on a policy level. It is, therefore, hard to evaluate the policy impacts or at least reflect on the various policy responses that recipient governments might be faced with if they sought to increase health sector capacity using financial support from HIV and AIDS GHIs.

In their study of the flows of the Global Fund, PEPFAR and World Bank MAP finances in Mozambique, Uganda and Zambia, Oomman et al. (2008) also assessed the country-level impacts of GHIs on human resources. They found that the impacts on human resources of the Global Fund varied, while PEPFAR human resources practices were much more uniform across the three countries (Oomman et al., 2008). PEPFAR funding mainly went towards funding the hiring of a substantial number of nongovernmental health workers, many of whom earned much more than civil servants (Oomman et al., 2008). In Mozambique, Zambia and Uganda, PEPFAR hiring practices and salary supplements were criticised for pulling staff away from their public sector positions by attracting them with better pay and work incentives (Oomman et al., 2008).

Global Fund and PEPFAR approaches to human resources that exclusively focus on HIV and AIDS can undermine health sectors that were already inadequately staffed. In their analysis of the interactions between the Global Fund, PEPFAR and World Bank MAP in Nigeria,

Chima and Homedes (2016) found that all three GHIs barely invested in the domestic production of new health workers. In some instances, government health policy makers redistributed health workers from facilities without donor-funded projects to ones with GHIs projects. This approach ensured that they were meeting the project targets established by funders (Chima and Homedes, 2015). Chima and Homedes (2016) therefore also criticised the HIV and AIDS GHIs for contributing to internal national brain drain by luring health workers from the public sector to non-governmental organisations.

In their literature review of the human resources practices of the Global Fund and two other GHIs, Vujicic et al. (2012) sought to understand the types of human resources activities that were eligible for financing; and the human resources activities that received funding. They found that there was little information available on how payment rates are determined, how the potential negative consequences are mitigated, and how payments are to be sustained at the end of the grant period (Vujicic et al., 2012). Based on their analysis Vujicic et al. (2012) argue that there was an opportunity for improved coordination between the three GHIs at the country level in human resources activities.

For instance, Vujicic et al. (2012) et al. found that regarding training content, the Global Fund grants tended to focus on training that was specific to the three priority diseases. They argued that one likely

reason behind the heavy emphasis on in-service training is because the Global Fund proposal evaluation criteria placed emphasis on applicants to show results within the time frame of the grant and thus potentially created a bias toward short-term, non-recurrent expenditure items for human resources (Vujicic et al., 2012).

Recipient countries have, however, also been criticised for not adequately taking advantage of the substantial funding provided by GHIs as an opportunity to strengthen their existing human resources capacity for their whole health sectors (Banteyerga et al., 2006; Drager et al., 2006). In Ethiopia, Banteyerga et al. (2006) found that money from the Global Fund went towards funding higher than normal salaries for individuals employed specifically to carry out HIV and AIDS interventions for non-government agencies. In some instances, Global Fund money was also used to top up some of the salaries of the regular employees assigned to work on Global Fund activities within government facilities (Banteyerga et al., 2006).

Banteyerga et al. (2006) found that, in Ethiopia, some of the tensions in regards to human resources challenges created by its relationship with the Global Fund were due to the country's general lack of a broad human resources strategy. In the baseline study, key issues included staff turnover and attrition, which appeared to be increasing with the growing shift of personnel from the public to the private sector due to the pull of Global Fund money. The follow-up study pointed to

worsening working conditions for staff in the public sector (Banteyerga et al. 2006).

In a five-year study funded by the European Commission, Cailhol et al. (2013) examined processes and policy contents of the human resources practices of Global Fund and PEPFAR in Angola, Burundi, Lesotho, Mozambique and South Africa from 2007 to 2011. Cailhol et al. (2013) sought to analyse the influence of external aid on countries' health policy and systems using the WHO's six building blocks of the health system. Through qualitative interviews of those involved in donor-funded programs at the national level, Cailhol et al. (2013) focused on evaluating policy changes on human resources over the period of study. In all countries, successful ARV roll-out was observed, despite generally perceived shortages of human resources for health. This result was viewed as coming about mostly because of a short-term emergency response by GHI-funded Non-Governmental Organisations (NGOs) and to governments increasing the available human resources for health to focus on HIV and AIDS tasks (Cailhol et al., 2013).

Cailhol et al. (2013) note, however, that the five countries slowly implemented mid to long-term HRH strategies, sometimes in collaboration with GHIs (Cailhol et al., 2013). Short term policies were plans implemented by local stakeholders without a formal regulatory framework, mostly via internal arrangement. Long-term policies were defined as those that backed-up by an official authority and a regulatory

framework, allowing standardisation and sustainability (Cailhol et al., 2013).

2.2.3 The Global Fund and Civil Society Engagement

In the Framework Document that initially defined its operations and governance structures, the Global Fund required that all country proposals for funding had to be developed and submitted through an in-country coordinating mechanism that solicited the input of relevant stakeholders impacted by and involved in addressing HIV and AIDS, TB and malaria within the applicant country. In Global Fund documents, this coordinating body is called the Country Coordination Mechanism (CCM) (The Global Fund, 2011b). The Global Fund defines CCM's as being "central to the Fund's commitment to local ownership and participatory decision-making" (The Global Fund, 2011a, p. 1).

This thesis only examines the influence of the Global Fund on the relationship between the Namibian Ministry of Health and civil society organisations in Namibia because the Global Fund initially and explicitly defined itself as seeking to promote country ownership through its funding application and disbursements processes (The Global Fund, 2011a). Through the establishment of the CCM in a variety of countries, the Global Fund gets credit for making the health systems of its recipient countries more pluralistic (Atun and Kazatchkine, 2009; Banati, 2008;

Doyle and Patel, 2008; Kapilashrami and McPake, 2013; Spicer et al., 2010).

Atun and Kazatchkine (2009) credit the Global Fund for having enabled strengthening of local health leadership to improve governance of HIV programs (Atun and Kazatchkine, 2009). The Global Fund is therefore seen as having enabled civil society and other non-governmental organisations to play a critical role in the design, implementation, and oversight of HIV programs. They also perceive the Global Fund's emphasis on inclusiveness and diversity in planning, implementation, and grant management as having broadly enhanced country coordination capacity. Thus by strengthening local leadership capacity and governance, they give the Global Fund credit for helping to build efficient and equitable health systems to deliver universal coverage of HIV services (Atun and Kazatchkine, 2009).

In South Africa and Zambia, Hanefeld (2010) found that in comparison to PEPFAR, the Global Fund was perceived as having better reflected country health system priorities through its requirements of a CCM:

There was a sense from interviewees in both countries that the GFATM [Global Fund] was more responsive to country needs than PEPFAR. Their perception was mainly based on the proposal development and mechanisms for implementation, which mean that Global Fund funding was based on national priorities rather than targets set globally (Hanefeld, 2010, p. 99).

The inclusion of CSOs in Global Fund mandated structures and processes have, however, sometimes been viewed as not reflecting a meaningful engagement in country responses to HIV and AIDS (Amaya et al., 2014; Banteyerga et al., 2006; Biesma et al., 2009; Kelly and Birdsall, 2010; Mtonya et al., 2005; Spicer et al., 2010). The Global Fund policy states that applicants are only required to establish a CCM if there is no existing alternate national coordinating mechanism. Most countries have, however, needed to create a CCM to access funding. In some instances, the establishment of a CCM has been found to lead to the duplication of existing multi-sector coordination structures for HIV and AIDS (Doyle and Patel, 2008; Kapilashrami and O'Brien, 2012; Mtonya et al., 2005).

The Global Fund has also been found to increase the complexity faced by governments as they attempt to coordinate the various efforts of the new or increased participants (Biesma et al., 2012; Brugha et al., 2010; Hanefeld et al., 2007; Harmer et al., 2013). The Global Fund helped to increase the number of actors involved in addressing HIV and AIDS. The GHI did not initially, however, spend much on strengthening the existing technical capacity and coordinating mechanisms of recipient countries (Biesma et al., 2009; Brugha et al., 2010; Caines et al., 2004). The Global Fund's requirement of a CCM comes with an explicit definition of what the term country ownership means.

In an evaluation commissioned by the Global Fund early on its existence, Brugha et al., (2005) evaluated the establishment and the

operations of CCMs for Round 1 funding for four countries: Mozambique, Tanzania, Uganda and Zambia. Their study found that all four countries appeared to have established a CCM in 2002 as an expedient way to access Global Fund money. On the one hand, Brugha et al., (2005) revealed that respondents thought that the CCM gave countries greater autonomy on deciding how to use the funding for the Global Fund when compared to other international donors. Respondents from Tanzania, Uganda and Zambia also remarked that the CCM often felt like a government coordinating mechanism, rather than a country coordinating mechanism due to the dominance of government representation, which made it hard for civil society to talk openly.

Brugha et al. (2004) found that respondents from Zambia, Uganda, Tanzania, and Mozambique had conflicted views on the role of the CCM. On the one hand, respondents revealed that the CCM gave countries greater "autonomy" on deciding how to use the funding for the Global Fund when compared to other international donors. There were, however, several problems with how the CCM ended up functioning both in the application for and implementation of Global Fund grants. Before the arrival of Global Fund resources, all four of the countries (Zambia, Uganda, Tanzania, Mozambique) had National AIDS Councils (NACs) that were underpinned by national legislation and had clear lines of accountability to either the President or the Prime Minister (Brugha et al. 2004; p.99). The establishment of the CCMs represented a duplication

in existing structures and led to tensions with NACs over respective roles and the control of funds.

In Zambia, CCM members apparently noted that they were not quite sure what to do once the application had been submitted (Brugha et al., 2005). A civil society CCM member was quoted after the signing of an agreement saying that members had not come together after the signing, as the role of the CCM was not clear after signing. They quoted a respondent who said "What will we be talking about when we meet? We don't control resources (Brugha et al., 2005, p. 98). The respondent was referring to the fact that even CSOs were engaged in the preparation of a Global Fund grant, it was ultimately the Government of Zambia that decided how to allocate most of the country's health resources. In India, Kapilashrami and McPake (2013) highlighted several barriers to effective participation in the CCM. They found that CCM meetings were often held at the launch of a new round either to finalise a country proposal or to submit the country progress report. As a result, the CCM's 'oversight' role was reported as negligible.

In Malawi, Mtonya et al. (2005) found that members of the CCM and government employees were often confused about what the functions of the CCM were supposed to be. When the Global Fund started operating in the country, the Ministry of Health was the primary steward of the health sector. The Global Fund's requirement for Malawi to establish a CCM duplicated the functions of the National AIDS Council (NAC)

Board. Its creation apparently produced confusion for existing health stakeholders as they were unsure of what the responsibilities of the CCM are supposed to be, as compared to those of the NAC Board (Mtonya et al., 2005).

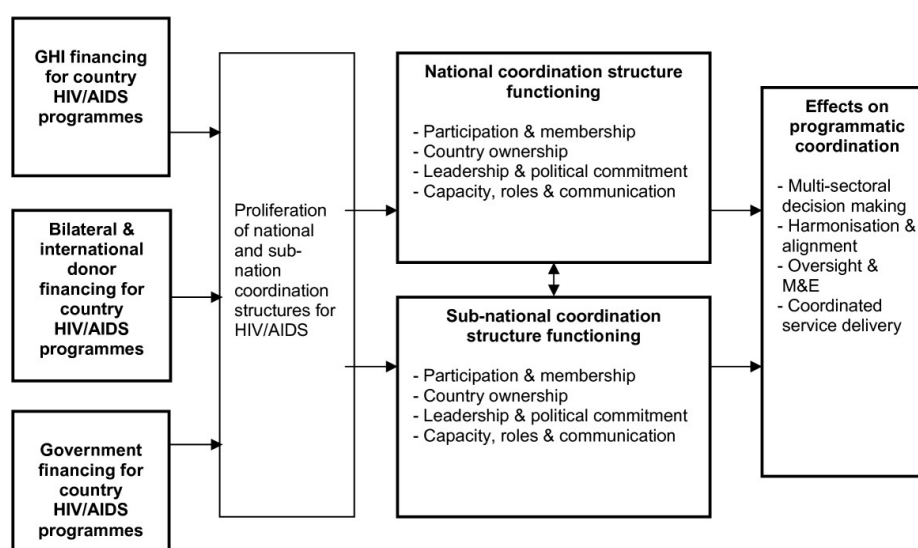
In Ethiopia, Banteyerga et al. (2006) found that when Global Fund resources first arrived in the country, the government had just started to implement a decentralised strategy for planning and for implementing health activities. By requiring the establishment of a CCM, the Global Fund-related planning processes did not adequately reflect the health sector's move toward decentralisation. For instance, the tight Global Fund deadlines did not allow room for the CCM and other central-level decision makers to quickly consult with and learn the priorities that the regions and other stakeholders would have wanted to contribute to the proposals (Banteyerga et al., 2006).

Based on empirical evidence from country studies forming part of the Global HIV/AIDS Initiatives Network (GHIN), Spicer et al. (2010) explored the effects on subnational and national coordination structures of the Global Fund, PEPFAR, and World Bank MAP. Their paper synthesised empirical qualitative data from seven country studies in Europe, Africa, Asia and Latin America: Georgia, Ukraine, Mozambique, Zambia, China, Kyrgyzstan, and Peru (Spicer et al., 2010). These studies explored the development and functioning of national and subnational HIV coordination structures and the extent to which coordination efforts

around HIV and AIDS were aligned with and contributing to strengthened country health systems.

Spicer et al. (2010) used the studies reviewed to define the functioning of national coordination mechanisms including Global CCMs. Their analytical framework seeks to capture three outcomes: a) GHIs and other financiers of country HIV/AIDS programmes; b) aspects of the functioning of national and subnational coordination structures; c) and the effects of coordination structure functioning on programme coordination (Spicer et al., 2010) (Figure 2.3).

Figure 2-3 Spicer et al. 2010 Framework for Examining GHI-supported CSOs



Spicer et al. (2010) revealed that the positive effects of GHIs included the creation of opportunities for multi-sectorial participation, greater political commitment and increased transparency among most partners. They found, however, that the quality of involvement by CSOs was often limited, and some GHIs bypassed pre-existing coordination mechanisms,

especially at the subnational level, and thus potentially weakened their effectiveness.

The multi-country study of coordination by Spicer et al. (2010), however, suggests that most CCMs continued not to perform the broad range of functions outlined in the Global Fund guidelines such as oversight and monitoring and evaluation: they primarily existed to agree and sign Global Fund proposals and met infrequently. Spicer et al. (2010) also found that in some cases, multiple coordination structures began to exist at the national and subnational levels, which either exclusively focused, or had a major focus on HIV and AIDS.

With a focus on the advocacy role of CSOs as supported by the Global Fund in Georgia, Kyrgyzstan and Ukraine, Harmer et al. (2013) examined of civil society advocacy efforts to reform HIV and AIDS and drugs-related policies and their implementation in the three countries. They argue that Global Fund support resulted in making CSOs more professional, which increased confidence from government and increased CSO influence on policies relating to HIV and AIDS and illicit drugs (Harmer et al., 2013). The findings by Harmer et al. (2013), however, also suggested that many CSOs became financially dependent on Global Fund grants. They quote several CSO staff sub-grantees in Ukraine who felt that financial dependence on short-term Global Fund HIV/AIDS grants undermined their ability to criticise the Government – which was the main recipient – for fear of losing further funding.

With a particular focus on Global Fund practices concerning NGOs (including CSOs) in Peru, Amaya et al. (2014) found that non-state agencies emerged as important actors due to their high representation in domestic HIV and AIDS coordination bodies. Funding from the Global Fund led to the emergence and participation of many new CSOs together with older ones. It had potential to contribute to them reaching vulnerable groups, strengthening the political position of these groups and increasing their training and overall capacity.

Amaya et al. (2014) found that the pattern of direct funding of CSOs as sub-recipients affected the steering role of the Peruvian Ministry of Health. Respondents from other sectors argued that the role of CSOs primarily as project executors, as facilitated by the Global Fund, hindered the CSOs' ability to advocate for their constituents and make the government accountable to agreements. Global Fund support made NGOs' committed to producing results – often in conjunction with national governments. Amaya et al. (2014) identified the CSOs' ability to assure government accountability as a key element to guaranteeing the continuity of Global Fund activities.

2.3 Ownership and Health Systems Implications of HIV and AIDS GHIs

Evidence demonstrates that scale-up of HIV services has produced stronger health systems and, conversely, that strengthened health

systems were critical to the success of the HIV scale-up (Palen et al., 2012). Increased access to and effectiveness of HIV treatment and care programs, attention to long-term sustainability, and recognition of the importance of national governance, and country ownership of HIV programs have resulted in an increased focus on structures that compromise the broader health system (Palen et al., 2012). In comparison to PEPFAR, Global Fund supported activities have been perceived as being more closely aligned with country ownership (Hanefeld and Musheke, 2009; Oomman et al., 2008).

In some instances, funding from the Global Fund and PEPFAR arrived within countries that were already providing some amount of HIV and AIDS services to their citizens (Farahani et al., 2014; Grundfest Schoepf, 2004; Schneider et al., 2006). These existing services imply that governments of these countries had some of the necessary health systems infrastructure in place to provide the health services that would then be buttressed by GHI funding. The health infrastructure of some recipient countries did not necessarily have the capacity to quickly translate the significant amount of financing that was made available through PEPFAR and Global Fund grants into health outcomes (Farahani et al., 2014; Hanefeld and Musheke, 2009; Schneider et al., 2006).

Some respondents interviewed for the study by Oliveira Cruz and McPake (2011) in Uganda explained that the rationale that drove GHIs like PEPFAR and the Global Fund to set up these parallel mechanisms

were related to the weak capacity of governments. If they had decided to work through the existing government structures, this would have delayed the implementation schedule of their activities (Oliveira Cruz and McPake, 2011). HIV and AIDS have the potential to increase the demand for health services, and at the same time as it has the potential to reduce the capacity of existing health service. As a result, access to antiretroviral treatment (ART) and other HIV-related services in the health sector are likely to place both positive and adverse effects on the supply of and demand for health services (Yu et al., 2008). It is difficult for health systems to provide HIV and AIDS services in isolation from other health services. A vertical approach works for a while, and then it hits the ceiling of insufficient health workers and dysfunctional health systems, particularly in countries with high HIV prevalence (Pearson 2004).

Drawing on evidence from Malawi and Ethiopia, Rasschaert et al. (2011) analyse the effects of the scale-up HIV and AIDS treatment interventions on human resources policies, service delivery and general health outcomes, and explore how synergies can be maximised. In both countries, the need for an HIV response triggered an overhaul of human resources policies. As a result, the health workforce at the health facility and community level was reinforced. In addition to a significant increase in the coverage of HIV and AIDS services, they observed a rise in user rates of non-HIV health services and an improvement in overall health

outcomes (Rasschaert et al., 2011). Thus interventions aimed at the expansion of HIV and AIDS services can have positive spill-over effects on the health system (Rasschaert et al., 2011).

In a case study of Ghana, Atun et al. (2011) aimed to explore how the Global Fund-supported HIV program interacts with the health system there and to map the extent and nature of integration of the national disease program across six key health systems functions (Atun et al., 2011). Qualitative interviews of national stakeholders were conducted to understand the perceptions of the strengths and weaknesses of the relationship between Global Fund-supported activities and the health system and to identify positive synergies and unintended consequences of integration. They conclude that investments in infrastructure, human resources, and commodities have enabled HIV interventions to increase exponentially. But Ghana's relationship with the Global Fund introduced governance and monitoring and evaluation functions, which were parallel structures to national systems, and led to inefficiencies (Atun et al., 2011).

Thus the aspects of health services provision and management that might serve as constraints to meeting general health system goals are some of the same ones that would impede progress for GHI interventions. Given the significant contributions of the GHIs, there are many questions around whether the HIV/AIDS money is strengthening or weakening health systems (Oomman et al. 2008). Based on their findings in Zambia,

Uganda and Mozambique, Oomman et al. (2008) argue that the establishment of parallel structures by HIV and AIDS GHIs is untenable and unrealistic. The AIDS-specific systems supported by funders also used many of the resources employed by the broader country health system. They used the same infrastructure and health facility workers, who must complete separate reports for donor health information systems, and their drugs were stored at the government facilities and delivered on the same trucks to many of the same health centres (Oomman et al. 2008).

The kinds of health worker skills required to address HIV and AIDS are not unique when compared to the skills needed to address a broad range of other health issues. For instance, within the hospital setting, the same skills needed to ensure efficient administration of and adherence to HIV and AIDS treatment are the same types of skills required to deliver other types of health programs (Callaghan et al., 2010; Marseille et al., 2002; Semo et al., 2014). Investing in the human resources infrastructure needed to deliver HIV and AIDS related services, therefore, has the potential to lead to a health system's improved ability to more efficiently provide other services (Banati and Moatti, 2008; Callaghan et al., 2010; Hanefeld and Musheke, 2009; McCourt and Awases, 2007).

According to Hanefeld (2014), within the first five years of the Global Fund's operation, it became apparent that the scale up of disease-

specific programmes was affected and potentially limited by weak health systems in recipient countries. Hanefeld (2014) argues that despite its potentially harmful system-level effects, the Global Fund created momentum regarding HIV and AIDS issues within focal countries, and highlighted the need for activities to strengthen systems, which otherwise may not have come to the fore (Hanefeld, 2014).

With a focus on Nigeria and the health system practices of the Global Fund and PEPFAR in the country, Chima and Homedes (2015) raised concerns that a particular focus on HIV and AIDS could be weakening health systems by diverting attention and scarce resources in the health sector. In Nigeria, implementing agencies were accused of caring less about ensuring equitable distribution of health services than about ensuring that they got good project numbers quickly, even at the expense of equity. Chima and Homedes (2015) found that facilities that were doing better at providing services tend to be selected for more support because such 'viable institutions' are more likely to scale up services with minimal support quickly.

Travis et al. (2004) argue that objectives based on achieving clearly specified targets within the short time frame can create a sense of urgency and provide a critical focus for addressing health issues:

The primary advantage of taking an intervention-specific approach to strengthening health systems is that it can help to maintain focus by targeting a "manageable chunk" of the system rather than taking on the whole. Targeting particular health-system constraints to the achievement of health goals may also deliver

quicker returns than longer-term, broader, system-based interventions (Travis et al., 2004, p. 902).

Long-term sustainability of health system capacity can be undermined by the benefits of short-time goals. Travis et al. (2004), therefore argue that a focus on larger health systems strengthening would address underlying causes of deficiencies in a system:

The advantages claimed of a system-wide approach are that such a strategy increases the range of options and tackles root causes, and the benefits accrue to several, not single, priorities, i.e., efficiencies are possible. The disadvantages are that benefits take longer to accumulate and the effort may become unfocused and unmanageable (Travis et al., 2004, p. 903).

Hafner and Shiffman (2013) argue, however, that while more funders now embrace health systems strengthening, this does not constitute a cohesive policy community. The concept of health systems strengthening is vague, and there is a weak evidence base for informing policies and programmes for strengthening health systems. They, therefore, question the sustainability of the sustainability agenda. From their criticism of the Paris Agenda, Goldberg and Bryant (2012) suggest that funder-recipient relationships for health interventions should start with an initial capacity assessment that includes both funders and recipients. By taking this approach, donors are acting in good faith because they position recipients to evaluate and increase health system capacity independent of whom is the source of external funding. The way in which capacity is built should not be defined by the donors, but should

instead use the existing capabilities of the recipient country as a starting point to strengthening health systems for the long-term.

This chapter has shown that Global Fund and PEPFAR practices at a national level have proven contrary to the principle of country ownership and institutional autonomy. Most of the literature reviewed refers to the potential negative implications for the recipients to maintain services at the levels that were facilitated by GHIs after their funding departs. The literature has, however, tended to focus on examining the impacts of GHIs while they are present in the recipient countries (Biesma et al., 2009; Chima and Homedes, 2016; Hanefeld, 2010; Kapilashrami and O'Brien, 2012; Oomman et al., 2008).

The existing research has shown less of an analytical focus on what might happen when they exit, given the ways in which they initially sought to direct their financial support. This thesis contributes to the literature that examines the practices of Global Fund and PEPFAR practices and their implications for country ownership and institutional autonomy. Before the year 2010, there are barely any academic writings that specifically address the issues of HIV and AIDS GHI transition at the country level. A few useful studies have, however, emerged since then (Amaya et al., 2014; Bennett et al., 2015; Craveiro and Dussault, 2016b; Marten, 2015). Looking at GHI practices over time has the potential to give a more comprehensive picture of their influence on health systems

strengthening, rather than just looking at them regarding the amount of funding that they provided at one point in time.

Amaya et al., (2014) examined the transition from Global Fund support to increasing national HIV and AIDS funding in Peru (2004–2012). They conducted thirty-five in-depth interviews from October to December 2011 in Lima, Peru, among the major stakeholders involved in HIV and AIDS work. From their findings, Amaya et al. (2014) argue that strengthening government and regional capacity and fostering accountability mechanisms will facilitate an effective transition to government-led financing. They position their study as providing lessons for countries seeking to sustain programmes following donor exit (Amaya et al., 2014).

For Peru, Amaya et al. (2014) argue that the vast amounts of funding that many countries receive to support HIV and AIDS interventions make the questions on how to sustain these programs central to understanding the current international development agenda. They define sustainability as "the capability of a government to manage health programmes long term without depending on the intervention of external bodies for technical or financial support within a given social, political and economic environment" (Amaya et al., 2014). By their definition for sustainability, Amaya et al. (2014) posit that their findings demonstrate that Peru made significant steps towards the viability of their HIV and AIDS response as funded by the Global Fund. They argue

that the creation of partnerships and initial alignment of Global Fund activities with national policies were found to be enabling factors for sustainability. The Peruvian government started the process of aligning Global Fund activities with local priorities early on. Alignment with existing structures then contributed to ensuring that activities were integrated into the national response and demonstrated a potential to be sustainable independent of support from the Global Fund.

Marten (2015) is another researcher that has recently sought to understand the impacts of GHI transition at a country level. In particular, Marten (2015) examines the issues of health system sustainability and country ownership of HIV programmes on Tanzania as impacted by the shift of PEPFAR funding and interventions in the country. Advocating for health systems strengthening while funds are still plentiful can be a good strategy for building health systems that are better able to deliver more sustainable and equitable care in many different countries. Marten (2015) argues that central to building the sustainability in PEPFAR's policies was the expansion of national ownership.

2.4 Thesis Research Contributions

A disproportionate amount of Global Fund and PEPFAR funding initially went to countries with a low-income ranking according to global

economic indicators (Druce and Dickinson, 2008; Hecht et al., 2010).

According to Hecht et al. (2010), Namibia, South Africa, Botswana and Swaziland "form a small group of countries combining high disease burden with middle-income status (defined as middle-income country as \$2250-5700 per head) (p.1256)." Until about 2003/04 there was minimal donor involvement in the Namibian health sector (MoHSS, 2010b; MoHSS and ICF Macro, 2010). From 2004 onwards, donor spending began to make up a larger share of total health expenditures. In 2001/02, donor funding as a percentage of total health spending in Namibia stood at 3.8% (MoHSS, 2010b; MoHSS and Health Systems 20/20, 2008). By 2006/07, donor contributions to the Namibian health sector had grown to 22.4% and then stood at 21.7% in 2008/09 (MoHSS, 2010b).

Much of the increase in external funds in Namibia was due to HIV and AIDS-specific funding from the Global Fund and PEPFAR (MoHSS, 2010b; MoHSS and Health Systems 20/20, 2008). As in many other countries, Global Fund and PEPFAR resources arrived in Namibia around the same time (MoHSS et al., 2010; Oomman et al., 2008). Thus the combined money from the two GHIs made a significant impact on the proportion of donor funding to the Namibian health sector.

Table 2-1 Funding of Namibian Health System 2001/02 to 2008/09: (MoHSS and Health Systems 20/20, 2008)

Namibian Government Budget Year	2001/02	2004/05	2006/07	2007/08	2008/09

Total Population (million)	1.83	1.92	1.99	2.018	2.051
Total Health Expenditure (real 2006 US\$ million)	261	393	549	524	551
Government Contributions to Total Health Expenditures (real 2006 US\$ million)	165	224	241	277	292
Government Contributions as a Percentage of Total Health Expenditures	63.3%	57%	44%	53.4%	53.8%
Donor Contributions as a Percentage of Total Expenditures	3.8%	9.7%	22.4%	20%	21.7%

Table 2.1 shows that between the financial years 2001/02 to 2006/07, total health spending in Namibia doubled during the 5-year period, going from US\$261million to US\$549 million (MoHSS et al., 2010; MoHSS and Health Systems 20/20, 2008). In 2000/01, the Namibian government contributed US\$165 million (63.3%) out of the total health sector budget of US\$261 (MoHSS and Health Systems 20/20, 2008). By 2006/07, the Government's contributions had increased to US\$241 million. However, despite the total increase in health sector budget, the Namibian Government's contributions only made up 44% of the total health sector budget for 2006/07 (MoHSS et al., 2010).

Within Namibia's National Health Accounts (NHAs), the increase in donor support as a percentage of total health sector spending has been mainly attributed to the presence of Global Fund and PEPFAR support (MoHSS et al., 2010; MoHSS and Health Systems 20/20, 2008). For

instance, in the Namibian Government's fiscal year 2008/09 for which 21.7% of health sector funding came from external funders, more than 90% of that funding came from either the Global Fund or PEPFAR (MoHSS et al., 2010). In the 2008/09 budget year, the PEPFAR initiative contributed 13.5% of total health sector spending in Namibia, while the Global Fund contributed 5.4% of total health sector spending (MoHSS et al., 2010). The contributions from the Global Fund and PEPFAR amounted to more than 18% of Namibia's total health care expenditures (MoHSS, 2010b).

There was an increase in the portion of the Ministry's budget that came from donors, as a result of funding that came from the Global Fund and PEPFAR. In 2001/02, the Ministry of Health received 96% of its funding from central government revenue and only 4% from donors. In 2006/07, 86.1% of its funding came from central government revenue, and 13.9% came from donors (MoHSS and Health Systems 20/20, 2008). Funding to the Ministry of Health primarily went towards the provision of clinical HIV and AIDS services at government-run facilities (Presidential Commission of Inquiry: MoHSS, 2013). In addition to their total contributions to the health sector, the resources from the two GHIs also led to a shift in the funding that the non-government health sector in Namibia managed. Between 2001/02 and 2006/07, the share of total health funds controlled by the Government fell from 57% to 43%, while the share controlled by NGOs rose from 1.6% to 16% during the same

period (MoHSS and Health Systems 20/20, 2008). This change in the proportion of NGOs controlling health sector funds is a reflection of the Global Fund and PEPFAR funding that was allocated to recipients besides the Ministry of Health.

Due to its HIV and AIDS prevalence, Namibia was initially one of the highest per capita recipients of both Global Fund and PEPFAR funding (Hecht et al., 2010; Youde, 2010). The country remains with one of the highest HIV and AIDS prevalence in the world, although there has been a clear transition in the financial attention that it has received from the Global Fund and PEPFAR (PEPFAR, 2011; The Global Fund, 2013a; The Southern African Development Community (SADC) and MoHSS, 2010).

Peer-reviewed literature that focuses on the interactions between GHIs and the Namibian health system is practically non-existent. No existing research questions the nature of Global Fund and PEPFAR engagement in Namibia with a focus on the issues of ownership and institutional autonomy, and their implications for health system capacity and the sustainability of this capability. Research on Global Fund and PEPFAR practices in Namibia primarily provides financial information on the involvement of the two GHIs in Namibia (MoHSS and Health Systems 20/20, 2008; PEPFAR, 2011). The background information on Namibia's engagement with the Global Fund and PEPFAR presented within this thesis mainly derives from documents produced by

stakeholders in the Namibian health actors, such as the Ministry of Health and Social Services, the two GHIs, and other national and international agencies operating in the country.

For this study, the Namibian context presented an opportunity to examine the impacts of changes in HIV and AIDS funding on the operations of a particular agency within a given country. This thesis seeks to make a research contribution on three main fronts:

1. It is a case study of the Namibian health sector concerning the Ministry of Health's engagement with the Global Fund and PEPFAR. It examines the extent to which the Ministry of Health was able to retain ownership of health policy development and implementation in its engagement with the Global Fund and PEPFAR through the rise and decline of funding to Namibia.
2. It examines the health systems policy effects of Global Fund and PEPFAR funding to Namibia mainly as associated with financial flows; human resources management; and civil society engagement.
3. This thesis examines whether the initial operations of the Global Fund and PEPFAR undermined country ownership and the autonomy of the Ministry of Health.

One of the main contributions of this research is to provide empirical findings on Namibia's health system, and its associated relationship with Global Fund and PEPFAR funding. Rather than GHI effectiveness being the focal point of analysis, the ability for Namibia to steer its health system in the presence of support from the Global Fund and PEPFAR is the focus of study. Another key contribution of this thesis is its attempt to understand the changing relationship that GHIs have on countries as they increase and decrease funding. It is easy to give GHIs a lot of credit

if the evaluation focus is only on understanding their contributions as they increase funding.

Spicer et al. (2010) argue that while single country studies and broad-brush reviews are starting to reveal the complicated relationship between GHIs and efforts to coordinate the HIV and AIDS response, synthesis of primary data from multiple countries is required to identify cross-country challenges and lessons learned (Spicer et al. 2010). Country situations differ widely in the sense that health systems are complex and their organisation and performance are highly context-specific; hence findings from other nations may not be entirely applicable to Namibia.

2.5 Summary

This chapter has examined the ways in which the existing literature on the country level interactions of HIV and AIDS GHIs has considered the issue of recipient ownership and its association with health systems strengthening. Although sustainability calls for greater integration into health systems, GHIs have often had to circumvented the recipient country systems to make a quick impact. The research emphasis has been on whether the health systems infrastructures of the beneficiary countries can enable GHIs to meet their objectives. In contrast, this thesis argues for a research focus that examines the extent to which GHIs

provide an additional boost of resources, which can then make the recipient countries better able to handle their affairs in the future.

Even as this thesis approaches the interaction of the Global Fund and PEPFAR with national health systems issue from the perspective of country's existing policies and operational arrangements, it draws from the analytical frameworks used in earlier studies that have approached the evaluation from the viewpoint of determining the effectiveness of GHIs. Previous studies are in particular useful for identifying the points of GHI and health system interactions from which an assessment of their relationship can commence.

The concerns around sustainability do not take away from the impact of GHIs. Rather it becomes a question of how GHIs can be made to be effective in the long-term. Strengthened health systems may become undermined if the starting relationship between GHIs and country health system subverts the autonomy of the recipient. Success in the presence of GHIs does not necessarily translate to continued health systems success after GHIs depart. There is the general tendency in the literature reviewed in this chapter to discuss country ownership as regards to the presence of donors. There is not enough discussion on the implications of that effectiveness once the donors have departed. Thus this thesis examines country ownership in the presence of the Global Fund and PEPFAR in Namibia, and its implications for a health system that remains strengthened once the two GHIs depart the country.

3. Research Design

3.1 Introduction

This chapter outlines the research design of the study and gives a reflective account of the research journey that underlies this thesis. Yin (1994) defines the research design as the “logical sequence that connects the empirical data to a study’s initial research questions and, ultimately, to its conclusions” (Yin, 1994, p. 19). The research design presented in this chapter is about the methods taken to examine the extent to which the Global Fund and PEPFAR influenced country ownership in Namibia at the rise and decline of their financial support to the country. With primary reference to the qualitative case study research design, this chapter describes the processes for data collection and analysis that were used to address the research aims described in chapters one and two.

As a research design, one of the strengths of the case study approach is its potential for the findings to be informed by more than one method for data collection (De Vaus, 2001). The results presented in this thesis derive from the analysis of data that was gathered from reading electronic and hardcopy documents; conducting semi-structured qualitative interviews, and from participating in and observing the Ministry of Health’s engagement with funding from the Global Fund and PEPFAR. Since the data for this thesis were collected through different

methods, which focus on the same issue, this study can be said to have adopted a multi-method approach (De Vaus, 2001).

This thesis uses multiple sources of data to qualitatively analyse the influences of Global Fund and PEPFAR support to Namibia from when the two initiatives were first established in 2002 and 2004, respectively, to 2012. The findings presented in this thesis derive from the analysis of data that was gathered from reading electronic and hardcopy documents; conducting semi-structured qualitative interviews, and from participating in and observing the Ministry of Health's engagement with funding from the Global Fund and PEPFAR.

A principal source of data was 43 semi-structured interviews conducted in Namibia during a placement with the Directorate of Special Programs in the Ministry of Health. Interview data was supported by observations gained from participation in Ministry of Health meetings and other discussions concerning the two GHIs. Interview data and participant-observation data were collected between February 2012 and June 2012, during the research placement.

3.2 Why the Qualitative Case Study Approach?

What is a case study? According to Gillham (2000, p. 1) the case study research design has four key features:

- 1) It is a unit of human activity embedded in the real world;
- 2) It can only be studied or understood in context;

- 3) It exists in the here and now; and
- 4) It merges in with its context so that precise boundaries are difficult to draw.

Gillham (2000) adopted these four characteristics of a case study from Yin (1994) who argued that the case study approach is particularly useful for examining contemporary events when the relevant behaviours cannot be manipulated (Yin, 1994, p. 8). The importance of real-life context is captured by qualitative research in general and in particular by a case-study approach (Diefenbach, 2009; Flyvbjerg, 2006; Ritchie et al., 2014). The case study approach is better suited than other research methodologies, such as a structured survey or quantitative analysis, to achieve this objective (Yin 1994). The defining feature of the case study is that it considers a phenomenon in its real-life context.

By emphasising the context, the case study approach allows the researcher to derive the significance of the research outcomes through reflecting on the context from which the data were collected (De Vaus, 2001, p. 235). By clearly situating the study within its larger context through description, the descriptive case study enables appropriate policy action to take place in response to the findings from the research (Hakim, 1987, p. 4). For health policy engagement at the global level, descriptive case studies from different geographic locations can be useful for answering questions on how to achieve an effective global health system (Szlezák et al., 2010).

A detailed understanding of the context of a single case study can provide ample information to determine if the findings from one context are applicable and replicable elsewhere (Flyvbjerg, 2006; Ritchie et al., 2014; Schofield, 2000a). In research on the interaction between the Global Fund, PEPFAR and country health systems, the country context has been found to be a mitigating factor for their perceived outcomes (Atun and Kazatchkine, 2009; Biesma et al., 2009; Collins and Beyrer, 2013; WHO Maximizing Positive Synergies Collaborative Group, 2009).

Although the context is important in explaining the findings from case studies, it can be difficult to delineate the boundaries of a research project. For practical policy implications, even the most clearly delineated unit of analysis does not mean that the causal factors of the outcomes within a study are clearly identifiable (Gillham, 2000; Yin, 1994). Within a larger and complex world, there are often multiple visible and invisible explanations for a perceived outcome. The multiple explanatory variables can then make it difficult for research to lead to the development of a clear and appropriate policy response to an issue (Gillham, 2000).

One of the challenges in any descriptive case study is answering the question of where to begin and where to end with the data collection. A case study deals with the whole case, but this cannot possibly mean that the case study consists of everything about the case. To describe everything is impossible: there must be a focus (De Vaus, 2001, p. 225). For policy research to be useful for practical considerations, it is

important to choose a unit of analysis for which the outcomes from the study could be practically applicable (Hakim, 1987, p. 132).

Regarding what the case study research design does, Hakim (1987), defines it as "the social equivalent of a spotlight or microscope". Its value depends on how well the study is focused (Hakim, 1987, p. 61). In the broadest sense, the 'case' within a case study design is the unit of analysis for which information is collected within a specified unit of time (De Vaus, 2001; Hakim, 1987). A case is the 'object' of study. It is the unit that we seek to understand as a whole (De Vaus, 2001, p. 220). The unit of analysis for a case study can be many different things. It can be an individual, group, institution or community (Gillham, 2000). A case can also be an event, a decision, a programme, an implementation process, and change within an organisation as a whole or even a change within a team or department (Rowley, 2002).

As will be described in Chapter four, the Directorate of Special Programmes (DSP) in the Ministry of Health is the Directorate tasked with the responsibility of overseeing and managing the Namibian Government's national response to HIV and AIDS (MoHSS, 2008ab). To focus the study, data collection within the Ministry of Health centred on the DSP (Rowley, 2002; Yin, 1994). Thus more narrowly, within the Ministry of Health, the DSP was the primary unit from which most of the interview and observation data were drawn.

For this research, the Ministry of Health is a case study embedded within the case of Namibia as a country. The Namibian health system consists of various government, private and non-government agencies seeking to address HIV and AIDS in the country. The Ministry of Health is just one of the organisations that could have been picked for analysis in Namibia. Through an embedded case study design, a phenomenon is more closely examined than it otherwise would be from a holistic design, which would seek to consider as many of the health system variables as possible (Yin, 1994). An embedded case study design ensures that the research has clear measures and seeks to avoid viewing an issue through an overly abstract lens (Yin, 1994, p. 42).

3.2.1 Single Case Studies and Issues of Generalisability?

The most frequent criticism of case studies is that they are often unable to meet the criteria of external validity, critical for verifiable research (de Vaus, 2007; Dooley, 2002; Flyvbjerg, 2004; Hammersley and Gomm, 2000; Rose, 1991; Schofield, 2000; Yin, 1994). The issue of external validity explores the likelihood that a case study will speak to situations beyond the one that was investigated, and therefore make the study generalisable (de Vaus, 2007; Dooley, 2002; Schofield, 2000; Yin, 1994). For purposes of generalisability, single case designs are considered to be the weakest of case study designs (de Vaus, 2007; Flyvbjerg, 2004; Yin, 1994). Applying the logic of replication, de Vaus (2007) argues that

"a single case design is less compelling than multiple case designs because it is only one replication and does not necessarily provide a robust test of a theory" (p.227). Replications give more confidence in the findings from research because there is always the possibility that if more case studies are done, some might not meet the researcher's expectations and thus demonstrate the need to revise the theory (de Vaus, 2007; Diefenbach, 2009; Yin, 1994).

In qualitative research, single cases are analogous to individual experiments in quantitative research and laboratory experiments (Yin, 1994). In this case study of the Namibian Ministry of Health, the findings from data collected were evaluated to determine whether they supported the theoretical propositions derived from existing literature (Schofield, 2000; Yin, 1994). Schofield (1993) argues, however, that unlike laboratory experiments, the purpose of describing the research design is not to enable someone else to replicate it and achieve the same results:

Rather it is to produce a coherent and illuminating description of and perspective on a situation that is based on and consistent with the detailed study of that situation (p.202).

As much as having multiple case study sites can increase the generalizability of qualitative work, Schofield (1993) argues that a study of a vast number of locations may also take away from a deeper understanding of an individual case (Schofield 1993, p.211). A detailed knowledge of the context of a single case study can provide ample information to determine if the findings from that context are applicable

elsewhere. In-depth descriptive work is necessary to demonstrate that findings are in fact comparable from one setting to another. This contextual understanding can also act as a determinant of whether the research would be worth replicating in another setting.

A case study calls for and requires an issue to be explored or understood within its original context (de Vaus, 2007; Flyvbjerg, 2004; Gillham, 2000; Gomm et al., 2000b; Luck et al., 2006; Rose, 1991; Stake, 2000; Yin, 1994). The meaning of human behaviour stems primarily from the context in which it occurs, and the case study research design is useful in allowing for a context-specific derivation of this meaning (de Vaus 2007, p.235). In seeking to embrace the context within which events occur the case study method demonstrates a strength absent in other research designs such as surveys, which are often premised on screening out the context (de Vaus, 2007; Yin, 1994; Yin, 1981). Generalisation of human behaviour often requires generalisation from one group of people to another, or one institution to another, all of which have many elements that are specific or unique to them (Evers and Wu, 2006; Gillham, 2000).

An in-depth description of the case study context is, therefore, necessary to demonstrate that findings are in fact comparable from one setting to another (Mitchell, 2000). Most other research designs rely on controlling out the influences of the context (De Vaus, 2001, p. 247). An experiment, for instance, deliberately divorces a phenomenon from its context, so that attention can be focused on only a few variables

(typically, the context is “controlled’ by the laboratory environment) (Yin, 1994, p. 13). Rather than seeking to screen out the context, as in experiments or surveys, case studies attempt to understand the significance of particular factors within the context (De Vaus, 2001; Yin, 1994).

For case studies, the engagement with the previous theory before data collection enables a researcher to select cases and units of analysis that are typical and representative of other situations and thus enhance the usefulness of case studies (De Vaus, 2001). Nationally representative policy research is more generalizable than localised studies (Hakim, 1987, p. 5). With particular reference to Namibia, the Ministry of Health was also chosen as the unit of analysis because it represents the national institution at which health policy is primarily legislated and operationalised in the country (El Obeid, 2001; MoHSS, 2008a).

Within qualitative case study research, a "thick" description of the study setting enables an independent assessment of the generalisability of a particular case study (De Vaus, 2001; Schofield, 2000b). Schofield (1993) argues that whatever the guiding principles of choosing a site may be, a “thick description provides the information necessary to make an informed judgment about the degree and extent to which the case of interest meets the criteria of typicality” (1993, p.210). A "thick" description of the study context also allows for an independent assessment of the extent to which the case at hand meets the criteria of

typicality for existing research (Schofield 1993, p.210). In addition to illuminating the situation in general, the contextual information provided within is meant to enable readers of this thesis to determine whether the study is generalizable to other contexts beyond Namibia (Evers and Wu, 2006; Schofield, 2000). Although this thesis focuses on the engagement of the Global Fund and PEPFAR in Namibia, the findings on the impact that they have on Namibia can add to a generalised understanding of the effects of the two initiatives at the country level, in other contexts.

Flyvberg (2004) argues that thick description is also necessary for accepting a case at face value rather than aiming to generalise it. The knowledge that cannot formally be generalised is also relevant and finds a way to enter into collective knowledge accumulation. As important as it is to be able to generalise from a case study, there is also value in the insights that can be revealed by an isolated incident (Flyvbjerg, 2004). Thus this case study of the Ministry of Health in Namibia is also useful as a standalone case for contributing to existing knowledge on the engagement of GHIs with country health systems.

3.3 Benefits of Research Placement with Ministry of Health

In November 2011, I emailed the director of DSP and requested a placement with the Directorate to enable me to collect data for this thesis. The application consisted of a formal letter of request with a

University of Edinburgh letterhead, a 2-page summary of the research objectives and my curriculum vitae (CV). The director approved my request for a research placement but informed me that I needed to apply for an official research internship through the Ministry of Health's Research Management Committee (RMC) for ethical review. On the 7th of December 2011, I submitted my full PhD proposal (as approved at the first-year PhD review that underlies this thesis, in July 2011) to the RMC. On the 20th of February 2012 (see Appendix 2), I was informed that the Ministry of Health ethical review panel had approved my request for a research placement with DSP.

In my initial letter seeking a placement with the DSP, I emphasised that the focus of the research was on understanding the health systems information requirements of the Global Fund and PEPFAR in Namibia. To accommodate my request, I was informed when I arrived that I would be located with the Division of Monitoring and Evaluation (M&E) to assist with activities within the division. I was given a desk, a computer, access to a telephone and an email address. For the three months that I was with the Ministry of Health, I worked official Namibian Government working hours (9 am to 5 am, Monday to Friday).

Although it became apparent that I would not be focusing the research on information systems early on, I continued to be engaged in activities related to M&E throughout the placement. For instance, I was involved in collecting data for the National Commitments and Policy

Index as well as the National Funding Matrix. The two databases were supposed to enable the department to develop its sustainability strategy but was mainly part of Namibia's report to the United Nations General Assembly Special Session (UNGASS) on the country's response to HIV and AIDS for 2010/11. On behalf of the Ministry of Health, which organised the event, I was also the transcriber for a multi-sector conference of the National AIDS Executive Committee (NAEC) held in April 2012.

3.3.1 Observations and Participation

When the phenomena under study are not purely historical, observations are a useful source of evidence because they enable the researcher to examine the context first-hand (Yin, 1994, p. 86). In my position as a DSP intern, I was both a participant and observer in Ministry of Health activities. From the first day of my three-month placement with the Ministry of Health, I kept a diary of my observations. I walked around with the notebook as I went about my daily activities with the Ministry of Health, and made notes of things that I thought might prove useful to the research.

As a result of the placement with DSP, I also found out early on that there are various components of the DSP operational structures that were not revealed in documents that I found through internet searches. Several documents only existed for public sharing in hardcopy forms. I thus kept an eye out for policy documents as I went about my activities

with the Ministry of Health. I also made notes of the various sources of data that were available for me to access. For instance, in an entry on the 12 of March 2012, I made a note of the fact that the Director of the DSP had newspaper articles on Global Fund and PEPFAR activities on her wall. I made a note to come back and read these articles. My notes also enabled me to keep track of policy documents I should make sure to look into, names of people, and organisations that could be useful to informing the study. The notebook also allowed me to start doing some preliminary analysis on the events that I was witnessing as well as on the data that I was collecting. In writing this thesis, I frequently looked back on these notes to track my thinking and understanding of the issues discussed within the thesis.

Since the placement with the DSP took place at around the same time that both initiatives were looking to decrease their funding to Namibia, the issue of country ownership and implications of the departure of GHI funding was already something that was on the radar of the Ministry of Health. Being in Namibia made clear that Global Fund and PEPFAR financial support to the country were on the decline. When I arrived in Namibia to collect data for research a Sustainability Technical Advisory Committee (TAC) was formed by the Ministry of Health to strategically plan for the decrease of Global Fund and PEPFAR funds. As part of the sustainability TAC, on the 27th of March 2012, I attended a Finance Strategy Meeting that was run by the Ministry of

Health (the DSP). Thus the data presented in this thesis ended up becoming driven by what was going in Namibia. As a representative of the Ministry of Health, I was able to attend a Namibian health sector stakeholder meeting, on the 29th of March 2012 at the Hilton Hotel in Windhoek, which mainly consisted of external funders to the Namibian health sector.

3.4 Documents

Documents were another important source of evidence for this study. They included printed and electronic books, peer-reviewed journal papers, policy white papers, annual reports, project reports, letters, emails, newspaper articles and blog posts. Most of the academic literature was accessed through Internet searches of journal databases such as EBSCOhost, Google Scholar, and the websites of the Global Fund and PEPFAR. Books and printed reports were obtained through the University of Edinburgh Library directly and through inter-library loans from other universities in the UK. Academic documents and articles were critical to helping me understand how to do research for a PhD thesis. Those relevant to qualitative research case study design helped me to understand some of the weaknesses, strengths and pitfalls of doing this kind of the investigation. The types of documents used and specifically referenced within this chapter were informed by lectures, readings and

discussion groups required in year one for all social sciences PhD student in the School of Social and Political Sciences.

Academic documents also informed my overall understanding of the perceived outcomes of the engagement between HIV and AIDS GHIs and country health systems. These were essential for helping me to understand the methodological approaches, theories and other issues that are critical to studying country-specific health systems of HIV and AIDS GHIs. When I first searched on the University of Edinburgh Library Searcher for documents relating to Namibia, there were very few documents relevant to this research.

On EBSCO Discovery Service, the website retrieved 670 entries under the subject Namibia. There were no books, book chapters or peer-reviewed articles that dealt with the question of the extent to which Namibia can exercise ownership in the presence of Global Fund and PEPFAR funding. On other websites such as Google Scholar, JSTOR, OCCLC AF, PubMed Central, World Cat, I searched for publications containing the general words Namibia and health, in conjunction with other broad words and terms such as:

- “Financing”
- “National policy”
- “HIV and AIDS policy”
- "Health sector organisations"
- "global health initiatives"
- "Funding, Global Fund"
- "PEPFAR funding"
- "policy history"
- "Ministry of Health and Social Services"

"Ministry of Health, Directorate of Special Programs"
"HIV and AIDS civil society organisations"

Academic documents on GHIs and health systems were useful for providing definitions of key terms; highlighting controversies and different positions; as well as providing ideas on the different directions and emphasis of the thesis research.

Documents are an important method for revealing how events are constructed (May 2001). Yin (1994), however, warns against a potential overreliance on documents in case study research. Documents are written for specific purposes and audiences independent of the case study research question, and should not be treated as if they contain "unmitigated truth" (Yin 1994, p.82). Yin's (1984) warning to be cautious of the intentions behind information contained in documents is especially relevant for the analysis in this thesis because peer-reviewed literature that focuses on the interactions of the Namibian health system with the Global Fund and PEPFAR is practically non-existent. The information on their engagement presented within this thesis was therefore mainly derived from descriptive documents which were produced by stakeholders in the Namibian health actors.

Policy documents as written for or by the Namibian Government and the Ministry of Health were essential to understanding the Namibian Government's stated objectives for the country's health sector. I started asking some interview respondents to identify the policy documents that

they viewed as most governing the Ministry of Health's goals and approaches to addressing HIV and AIDS. Policy documents provided an understanding of the Ministry of Health's defined practices for overall engagement with external funders; existing practices and objectives for HIV and AIDS; and current practices and goals for financial flows, human resources management and civil society participation.

The documents were also important for helping to provide me with understanding the institutional origins, policy objectives and operational structures of the Global Fund and PEPFAR. Important historical documents that provided funding information included original funding agreements between the Ministry of Health and the Global Fund; signed agreement between the Ministry of Health and PEPFAR; and Namibian Government proposals to the Global Fund. Newspaper articles written before and during my research placement with DSP also informed me of the issues that were considered as important by Namibians concerning Global Fund and PEPFAR money.

Understanding the structure of the DSP and other organisational arrangements between the Ministry of Health, the Global Fund and PEPFAR was critical to meeting the objectives of this thesis. There were a variety of useful documents that were only available as paper from the Ministry of Health and other relevant agencies such as the National Planning Commission and the Office of the Prime Minister. There were several documents that I was only able to discover because I was

physically in Namibia and able to search around and explore if there were any relevant documents that could be used for this thesis. For instance, there were some policy documents that I discovered by spending time in the Resource Centre of the Ministry of Health and the library at the National Planning Commission.

3.5 Interviews

Interviews are important sources of data when a case study deals with human affairs (Yin, 1994), as this research does:

...human affairs should be reported and interpreted through the eyes of specific interviewees, and well-informed respondents can provide important insights into a situation. They can also provide shortcuts to the prior history of a situation, helping you to identify other relevant sources of evidence (Yin, 1994, p. 85).

Semi-structured, in-depth, qualitative interviews were the primary source of data for this study. In total, I conducted 43 interviews for analytical purposes with individuals from organisations associated with the Global Fund and PEPFAR programs in Namibia. Respondents were senior management officials from the Ministry of Health, U.S Centres for Disease Control (CDC) Namibia, and the United States Agency for International Development (USAID) Namibia, the PEPFAR Country Coordinator Office and the Global Fund Program Management Unit in Namibia. Further respondents came from NGOs in Namibia.

The interviews were all conducted in Namibia. They took place over three months primarily occurred during the fourth semester of the PhD studies. Interviews were used to provide a more detailed understanding of the priorities and objectives of the three actors, their undocumented interactions, and their perceived tensions or confluences. Due to the limited time available for conducting interviews, the strategic decision was made to interview respondents from Umbrella NGOs that were associated with the Global Fund and PEPFAR programs in Namibia. Respondents came from the Namibian Council of Churches, Namibian Business Coalition on AIDS, Namibian Network of AIDS Services Organisations, National Planning Commission, Ministry of Education, and the Office of the Prime Minister.

Because of their professional authority within the organisations that they worked for, the interviews were with individuals who would be considered elite (Gillham, 2000; Hakim, 1987). Elite respondents are recruited on their perceived in-depth awareness of an environment or an issue (Hakim, 1987). They are most useful when they are capable of giving answers with insight and a comprehensive grasp of the subject under inquiry (Gillham, 2000, p. 63). The specialised knowledge of elites makes them both informants and respondents for a study. The interviewer needs to demonstrate a good deal of prior knowledge of the subject of inquiry during the interview to get comprehensive answers to the questions posed (Hakim, 1987, p. 74).

In order to enhance my contextual understanding of Global Fund and PEPFAR operations in Namibia, I initially conducted nine informational interviews with officials from the Ministry of Health, CDC, PEPFAR Country Coordinator Office and the Global Fund PMU. They were structured discussions that focused on providing background information on the Namibian health sector independent of and with Global Fund and PEPFAR funding. The informational interviews were conducted to provide useful background knowledge, which would facilitate the elite interviews. I further prepared for the analytical interviews by reading documents on the Namibian health systems before and during the research placement with DSP, and through having informal conversations with officials from the Ministry of Health and other agencies. My time with the Ministry of Health gave me a contextualised understanding of the organisational roles of various interviewees and enabled me to engage with them on an individual basis during the interviews.

3.5.1 Respondent Identification and Recruitment

In total, there were 43 interviews conducted with a variety of Namibian health stakeholders (see table 3.1 for their organisational affiliation). The way in which the sample of respondent was recruited was informed by the existing Namibian policy and institutional arrangements concerning the Global Fund and PEPFAR. Respondents were selected

from their involvement in HIV work or expertise during the period of study, as well as direct or indirect participation in Global Fund and PEPFAR projects. Before the research placement with DSP, I reviewed policy documents, which revealed the organisations and that were associated with the Global Fund and PEPFAR programmes in Namibia.

Table 3-1 Organisational Affiliation of Interview Respondents

Ministry of Health	11
Global Fund Namibia	6
CDC Namibia	6
Multilateral Agency	5
Private Sector	3
Other Namibian	
Government Agency	5
Civil Society Organisation	7
Total Respondents	43

The sources of information primarily included policy documents that were either written by the Ministry of Health or by the two initiatives. Once I had identified the organisations that would be useful, I asked around and read policy documents, and read conference and workshop minutes and attendance lists to determine the individuals who tended to be present at events relevant to the Ministry of Health's relationships with the Global Fund and PEPFAR. From this preliminary review, I created an initial list of the individuals that I wanted to interview. During the first three weeks of my research placement with the Ministry of Health, I refined the respondent's list from information gained from informational interviews and informal conversations with

individuals associated with the two initiatives in Namibia. By being based within the Ministry of Health, I was also able to secure interviews that might have been difficult to obtain. I often had to go back to the offices of some respondents a few times just to make sure that I was catching them at a good time. I went to the office of one person in the Ministry of Health about six times in an attempt to secure an interview but ended up being unsuccessful.

Interview respondents were recruited via email and in-person. For Ministry of Health officials, I either approached the potential interviewee directly in-person or asked someone in DSP to introduce me and my research. I met many of the non-Ministry of Health respondents at meetings and events that I attended in my capacity as an intern for DSP. I either requested an interview with the interviewee when I first met them or sent an email to them later requesting an interview. I obtained the contact details of individuals by either asking them for their contact information when I first met them; by asking to be connected to them by mutual acquaintances (usually someone from the Ministry of Health); and by copying the contact details, they provided on sign-up sheets at workshops and conferences.

By directly speaking to people about their expected jobs as well as the ways in which these roles played out, I was better able to understand the terms of engagement between the Ministry of Health and the GHIs. For instance, in one informational conversation with an individual

directly associated managing human resources for PEPFAR funding, I answered a lot of questions on the influence of GHIs at both the rise and fall of financing to Namibia just by speaking to the respondent at length about what they did in their everyday job. By participating in Ministry of Health activities, I gained access to individuals from other relevant Namibian government bodies and international organisations such as UNAIDS, USAID, National Planning Commission, Ministry of Health Education. I got the impression that since individuals from these agencies met me while I was engaged in activities on behalf of the Ministry of Health, they were more willing to talk to me because my association with the Ministry made me seem like a legitimate stakeholder.

3.5.2 Interview Process

No analytical interviews were conducted during the first month of the placement. That month was used as a time for observation with the purpose of understanding how things operated in the Ministry of Health (See Appendix 5). All interviews were one-to-one and face-to-face. The interviews primarily took place in the offices of respondents. An interview guide was used for all meetings. Through the discussion guides, I defined the topics that were important. The interview questions required respondents to provide information on the organisations that they worked in, not on themselves. Respondents were asked to reflect on the

characteristics, activities, and processes and events taking place within the Ministry of Health (Hakim, 1987).

During the interviews, the interview guide was a tool to help keep the conversation focused on the research question (See Appendices 6, 7 and 8 for different interview guides). However, given that the respondents were accessed for their specialised knowledge, I left it to them to bring to my attention the issues that they thought would be relevant to the study inquiry based on their in-depth understanding of the situation. As long as they stayed on topic, respondents were encouraged to describe the relationship between the organisations in their words (Richards, 1996; Rubin and Rubin, 2011).

Most of the interviews were conducted in April 2012. There was, however, one interview in which I had to join the interviewee during lunch at a hotel as they were taking a break from a conference they were attending at the hotel. On average, the interviews were 1-hour long. The shortest interview lasted 40 minutes, and the longest was 2 hours. Aside from one, all interviews were recorded with an electronic audio recording device after seeking written confirmation from respondents.

When compared to just writing what an interviewee is saying, recording interview conversations enables the interviewer to concentrate on and engage more with what is said (Richards, 1996; Yin, 1994). I found that I was more quickly and directly able to listen to what the respondents were saying when I did not have to worry about hurriedly

writing down everything that they said. Recorded interviews also enable the interview conversation to be transcribed word-for-word, which makes it easier to later analyse the information received (Richards, 1996). For this research, the recordings of all the interviews were transcribed word-for-word and organised using Microsoft Word.

In asking representatives from external funders to reflect on their influences in Namibia, I asked them to think about both their history and future in the country. In the interviews, I was mainly seeking to understand the extent to which respondents viewed GHI activities as integrated within the Ministry of Health. I was then asking respondents to reflect on the degree to which they perceived actions as requiring more integration. For Ministry of Health respondents, I asked them to think about operations both independent of and in association with GHIs.

3.6 Ethical Considerations

The ethical issues that need to be addressed for case studies largely depend on the methods used to collect data (De Vaus, 2001; Ritchie et al., 2014; Rubin and Rubin, 2011). For example, the ethical issues will be different if the case study involves an active intervention or a passive intervention. The ethical issues will also differ according to whether data are collected by interviewing individuals, using informants, analysing official records, passive observation, conducting a survey of

case elements, or using participant observation (De Vaus, 2001). Under the University of Edinburgh ethics procedures, in July 2011, I carried the Self-Audit Checklist for Level 1 Ethical Review. The research design of this project was therefore confirmed as Level 1. It "did not present complex ethical issues and did not require formal ethical review" (The University of Edinburgh, 2011). The answers to all the questions on potential ethical risks were "no", and this PhD project was confirmed as Level 1 as it identified no particular ethical risks. The ethical review process through the Ministry of Health's RMC also did not identify any ethical risks to respondents (See Appendix 2).

Respondents were, however, still made aware of the ethical implications of being interviewed for the study. Before the first interview question was asked, each interviewee was required to read an information sheet that described the goals of the research (See Appendix 3). They were then requested to sign a consent form, which informed them that the interviews would be recorded, and of how the data would be protected (See Appendix 4). There were different reasons for asking respondents to sign a consent form. The consent form that interview respondents were asked to sign sought to achieve the following:

- To help interviewees understand why they were being interviewed and make them aware of the potential risks.
- Provide interviewees with with sufficient information for reasoned and free decision on whether to take part in the interview

- It was made clear to respondents that participation was not mandatory. They could refuse to answer questions and withdraw from being interviewed, when if they wanted to.

There was a confidentiality provision within the consent form, which sought to assure respondents of two main things:

- The voice recordings and transcripts of interview data are stored safely and with restricted access.
- The sound recordings and transcripts and other data would not be shared in a way that directly linked to the respondent, without explicit consent from the interviewee.

When respondents are accessed for their professional knowledge, documents such as consent forms enable officials to protect themselves as the source of information revealed through the interviews (Gillham, 2000). This control is, however, subject to the researcher/interviewer keeping their word that data would be stored as indicated in the consent form, and that respondents could not be easily identified by the information presented in this thesis.

The respondents interviewed were some of the key decision-makers in Namibia's engagement with the Global Fund and PEPFAR within their organisations. As an interviewer, I needed to remain sensitive to the fact that it was highly possible that their public opinion might be very different from their private views (Hakim, 1987). While located within the DSP, I was an observer of things such as the arrangements of offices and dynamics between various colleagues (Yin, 1994). My placement with DSP had potential to be ethically tricky when taking into account issues of informed consent and voluntary participation. De Vaus (2007) argues,

however, that so long as certain behaviours already occur publicly, then the issue of informed consent to observe those actions is not as important as long as individuals are not identified by name (de Vaus, 2007).

However, given that the respondents interviewed for this thesis were interviewed within their official capacities, it is vital to protect their identities. Depending on what aspects of institutional arrangements and dynamics are being described, it might still be hard to fully hide the identities of respondents even when their names are not specified.

3.7 Data Processing and Analysis

Because data collection and analysis processes tend to be concurrent, with new analytic steps informing the process of additional data collection and new data informing the analytic processes, qualitative data analysis processes are not entirely distinguishable from the actual data. The theoretical lens from which the researcher approaches the phenomenon, the strategies that the researcher uses to collect or construct data and the understandings that the researcher has about what might count as relevant or important data in answering the research question are all analytic processes that influence the data (Ritchie et al., 2014; Rubin and Rubin, 2011).

Although there are many qualitative data analysis computer programs available on the market today, these are essential aids to

sorting and organising sets of qualitative data, and none are capable of the intellectual and conceptualising processes required to transform data into meaningful findings (Ritchie et al., 2014; Saldana, 2013). A key aspect of data analysis is how the data is coded (Saldana, 2013). The type of coding, however, depends on the type of research that is conducted. As identified by Saldana (2013), some of the key types of coding methods implicitly and explicitly incorporated in the analysis of interview data for this thesis are grammatical, elemental and exploratory methods (Saldana, 2013):

- Grammatical methods relate to the type of coding approaches that apply grammatical principles. For instance, in attribute coding, essential information about the data and demographic characteristics of the participants is noted for future management and reference. According to Saldana (2013), virtually all qualitative studies (including computer-assisted coding employ attribute coding).
- Elemental methods of coding are primary approaches to qualitative data analysis. They have basic filters for reviewing the body of work and build a foundation for future coding cycles. For instance, descriptive coding assigns basic labels to data to provide an inventory of their topics.
- Exploratory coding methods are exploratory and preliminary assignments of codes to the data before more refined coding systems are developed.

Since qualitative inquiry is an emergent process of investigation, these coding methods are tentative labels as the data are initially reviewed. Holistic Coding applies a single code to each large unit of data in the content to capture a sense of the overall contents and the possible categories that may develop. At the start of data, analysis, I extensively applied holistic coding to the interview data (Saldana, 2013) (See

Appendix 9 for the an example of some of the main issues that initially emerged from interview data).

I initially transcribed the first interviews soon after they took place, often on the same day on which they occurred. It, however, became time-consuming to keep this up as I conducted more and more interviews. For instance, on the 28th of April 2012, I had four different meetings on the same day. In the end, transcribing the interviews took almost four months from when the interviews were mainly. I transcribed the interviews by listening back to the recordings of the conversations with respondents. I then wrote down every word that was said, indicating whether it was me who said something or whether it was said by the interviewee.

During and after the placement with the Ministry of Health, the methodological approach of the research and thesis did not change much from what was decided when I went to Namibia to collect qualitative interview data. What did end up changing was the particular focus of health issues that were presented in the thesis. The thesis focus was informed by the issues that appeared to matter to Namibians during the interview data collection.

Using the same logic that underlies the function of qualitative data analysis software packages, interview data were organised with the Table of Contents and Headings functions of Microsoft Word. Quotes from various respondents that dealt with specific themes or issues were

grouped under headings and sub-headings. A table of contents list was then produced from the headings and sub-headings. The table of contents enabled me to quickly locate and analyse interview respondent quotes under their appropriate themes.

There was a lot of data available, so I decided to reduce the amount of data that needs to be digested by focusing on re-occurring themes. I described data, noted ideas and categorised ideas and issues so that I could incorporate them into the thesis. During preliminary data analysis, the focus was on identifying issues. The initial analysis of the data was what enabled me to identify some of the major problems that were viewed as important by both the interview respondents and the larger Namibian policy environment. I was able to identify what appeared to be significant connections between the processes by which the Ministry of Health was required to engage with the Global Fund and PEPFAR, and the concerns that respondents raised about ownership.

Although the findings from my placement with the Ministry of Health revealed to me that the thesis was going to have a general focus on financial flows; human resources management and civil society engagement, it was hard to determine the angle from which to tackle these issues. The approach to the problem of human resources was the easiest of the three themes because the problem of human resources management dominated discussions in Namibia concerning the exits of

the Global Fund and PEPFAR. Thus this made it clear to focus on an issue that the Ministry of Health viewed as critical.

After the interviews, the documents were used to corroborate and augment information from the interviews (Yin, 1994). I also used documents verify the correct spellings of names of individuals, processes, policies and organisations. They were also used to check the dates and places of events that were revealed during the interviews. It significantly makes a case study more convincing and accurate when its sources for evidence corroborate each other (Yin, 1994). I triangulated the evidence that came from participant observations, with data from documents and interviews to determine if it converged to tell the same general story concerning the focus of the study inquiry (Gillham, 2000; Yin, 1994). When data from different methods converge (match), then we can be reasonably confident that we are getting an accurate picture. If they do not match, then we have to be cautious about basing our understanding on any one set of data (Gillham, 2000, p. 13).

3.8 Case Studies and Issues of Subjectivity

When compared to other methods for data collection, the qualitative case study approach has faced criticism for not being scientifically rigorous because of the individual role that the researcher plays in both collecting and analysing the data (Yin, 1994). It has been

viewed as much more biased towards the views and attributes of the researcher than other forms of research (Flyvbjerg, 2004; Schofield, 2000; Yin, 1994). Gillham (2000) argues, however, no research investigation is without subjectivity (p.7):

A research study is not neutral; it has its dynamic, and there will be effects (on individuals, on institutions) precisely because there is someone there asking questions, clarifying procedures, collecting data.

Gillham (2000) is arguing that all research is inherently subjective. Even in quantitative studies, someone decides on the topic and conducts the research. Scientifically rigorous studies call for a refutable hypothesis or question. The question itself, however, is rooted in the opinions of the person asking it. A refutable hypothesis allows for a fair evaluation of whether the evidence supports or disagrees with the original opinion (Evers and Wu, 2006; Flyvbjerg, 2006; Mitchell, 2000). Subjectivity is inherent in both the choice of the research questions and how they are asked.

Subjectivity in research is therefore not necessarily a negative thing. To advance human knowledge, Flyvbjerg (2004) argues that subjectivity in qualitative research is a strength rather than a limitation (p.429):

If one assumes that research, like other learning processes, can be described by the phenomenology of human learning, it then becomes clear that most advanced form of understanding is achieved when researchers place themselves within the context being studied. Only in this way can researchers understand the

viewpoints and behaviours that characterise social actors.

Flyvbjerg (2004) is arguing that, in essence, by being human, a scientist cannot help but be touched and should, in fact, embrace their unique contribution to the issue under investigation. In qualitative case study research, "intellectual rigour goes together with personal conviction as in any other profession (Diefenbach, 2009, p. 877)". My nationality as a Namibian and the country's global political position influenced my choice of the focus of this research. My connection to the country, as well as cultural knowledge of the country, were also an advantage both in securing the placement with the Ministry of Health and in enabling me to engage the various respondents quickly.

The staff from Monitoring and Evaluation were very accommodating and generous with sharing their data. I was given a variety of policy documents to help me familiarise myself with HIV and AIDS systems, and data collection in the Ministry of Health. Many DSP staff were eager to give me their opinions about the two initiatives under study. Early on in my time with the DSP, I happily noted in my research diary, "Everybody is so super helpful" (12 March 2012). People, however, were most candid with me about their perceptions on external funding when they were alone with me. For example, early on (13 March 2012), I overheard a conversation between two DSP staff, in which one of the people was expressing frustration and annoyance on the influence of PEPFAR on human resources practices. This conversation took place in

my native Namibian language, Oshiwambo. At the time, the people having the conversation were not aware that I spoke Oshiwambo. It was not an issue that I had hidden from anyone. It just had not come up before. I would not have been aware of this situation if I had not been in the room, and if I did not speak the language.

This conversation ended up opening up some key questions for me on Global Fund and PEPFAR practices for human resources management, which was pivotal to framing the findings presented in Chapter six. On the day that I overheard the conversation, one of the notes that I made to myself was: "Ask about recruitment procedures as well as the various organisations involved in making decisions on human resources (13 March 2015)".

It was important not to allow myself to be captured by the DSP. It was important to remember that the thesis seeks to add to a theoretical understanding of GHI interactions with country health systems. As a Namibian, I was inclined to side with the position of Namibia in my analysis of the observation, interview and documentary data. I had to remind myself of reflexivity so as not to allow the research to be dictated by context. My perceptions within the research context are important, but I had to strive to ensure that I kept a focus on the issue of country ownership. I got distracted by all the various things going on, and I needed to constantly remind myself to remain focused and not go chasing every issue or controversy.

As a Namibian who lives abroad, my biases come from the fact that I was interested in the extent to which external funders viewed Namibians as something to be managed instead of providing funding to enable recipients better to govern themselves. I got caught up in my larger concerns around the ways in which international actors view the role of developing country recipients as they seek to provide them with financial support. As a participant in Ministry of Health activities, I sometimes became quite vocal in representing the interests of DSP. I then had to remind myself to remain neutral. Ultimately, the goal of scientific research is not to prove if the hypothesis is infallibly wrong or right. The goal is to show that the evidence plausibly supports the presented opinion. The goal is to make a sound scientific contribution, which is carried out according to sound, accepted, scientific procedures (Flyvbjerg, 2006). This chapter has aimed to describe the methods applied to produce this thesis.

3.9 Summary

This chapter describes the research design that underlies the findings presented in this thesis. It details the research design as a qualitative case study approach, which uses evidence from interviews, documents and participant observations. The chapter shows what was done to reach the findings and conclusions presented in the ensuing

chapters as a means to demonstrate this study's internal validity and argue for its external validity. The chapter started off by justifying the choice of the qualitative case study approach for the research. It explained why the case study method is useful when a phenomenon is explored within its context.

Within the Namibian context, the chapter then justified the choice of the Ministry of Health as the primary unit of analysis for the research. The Ministry was also chosen because it represents a similar unit of study for other studies on the country-specific influences of the Global Fund and PEPFAR. The chapter explained the focus on the DSP, which is the directorate tasked with managing the Ministry of Health's national HIV and AIDS response. Through an embedded case study, of the DSP within the Ministry of Health, the study was able to pinpoint the level where a change occurred. The placement with the DSP facilitated access to documents and relevant stakeholders.

The findings presented within the ensuing empirical chapter are primarily based on data from semi-structured qualitative interviews with senior management individuals that work for organisations associated with the Global Fund and PEPFAR programmes in Namibia. Within the Ministry of Health, interviews were primarily conducted with respondents related to the DSP. The findings from the interview data were corroborated and augmented with evidence gained from documents and participation in and observation of Ministry of Health activities.

Case studies have been criticised for not being widely generalisable. Generalisability can be improved through replications in the form of multiple cases, but, as in this research, these are not always feasible, and a single case has to suffice. A single case study approach is, therefore, a limitation of the research design for this thesis. Finally, case study research has been criticised for being more subjective than other forms of research. This chapter showed, however, that subjectivity occurs in all research because humans are involved in the process.

4. Namibian HIV and AIDS Policy Context

4.1 Introduction

The purpose of this chapter is to introduce the Namibian health sector within the context of the Ministry of Health's response to HIV and AIDS, and its overall institutional relationship with the Global Fund and PEPFAR. This chapter starts by describing the role that the Ministry of Health has played in the national response regarding overriding policies and their associated institutional arrangements for HIV and AIDS. The chapter then describes the types and amounts of financial contributions that the Global Fund and PEPFAR have made to Namibia. The chapter also introduces some of the agencies within the country, which have been associated with funding by the two initiatives.

4.2 Namibian Health Policy Foundations

The origins of Namibia's post-independence health policy framework are similar to that of the country's constitutional framework. It was developed within the context of United Nations-led support to prepare the country for independence (Kaela, 1996; Namibia Support Committee et al., 1984). Between 1938 and 1990, South Africa governed Namibia as one of its provinces. As a reflection of the apartheid policies in its country, the South African Government established self-governing

homelands for non-white population groups in Namibia in 1968 (Cliffe, 1994). The homelands were divided according to the 11 ethnic identities in Namibia. All public services including health were provided along racial and unequal means, favouring white people (Namibia Support Committee et al., 1984).

A 1980 health sector assessment established the blueprint to Namibia's post-independence health policy framework in a policy document titled A Country Health Programme for Independent Namibia. Within this document "Health for all by the year 2000 through Primary Health Care (PHC)" was established as the overriding goal for an independent Namibia (Namibia Support Committee et al., 1984). This strategy was a reflection of the WHO's general strategy for health, following the Alma Ata Conference of 1978 at which "Health for All" was established as the desired outcome for health by UN member states (World Health Organization, 2010).

Following independence, the Namibian Government consequently adopted the PHC approach as the main strategy for implementing health interventions in the country (MoHSS, 2009). In 1990, the newly elected Namibian Government established the Ministry of Health and Social Services (MoHSS) to oversee the national response to health in the country by designing, developing and implementing health programs for the whole population (MoHSS, 2009). Through the Ministry of Health, the Namibian government mainly set out to redress the pre-independence

health inequities, which had been perpetuated by the Apartheid government of South Africa (MoHSS, 1998).

4.2.1 National HIV and AIDS policy and institutional arrangements

The Namibian health system has two main components: a public service and a private sector. The Government provides the public health services through the Ministry of Health and Social Services (Ministry of Health). Private health services are delivered by private practitioners, private hospitals and clinics, and by traditional healers (El Obeid et al., 2002). Since the country gained independence in 1990, the Government has been estimated to provide 75%-80% of all health services in Namibia annually (Ministry of Health, 2005; Ministry of Health, 2007a; Ministry of Health and Health System 20/20, 2008; Office of the President of Namibia, 2009). Faith-based organisations, which are fully subsidised by the Government, have been found to provide approximately 10% of total health services, while the private sector provides the remaining 10% (Ministry of Health, 2005; Ministry of Health, 2007a; Ministry of Health and Health Systems 20/20, 2008).

The Namibian Government is the largest source of revenue for the Ministry of Health through general taxation (Ministry of Health, 2003; Ministry of Health, 2006; Ministry of Health, 2010; Office of the President of Namibia, 2009). The Namibian public health sector is governed at two levels, the national and regional levels (el Obeid et al., 2002; Low et al.,

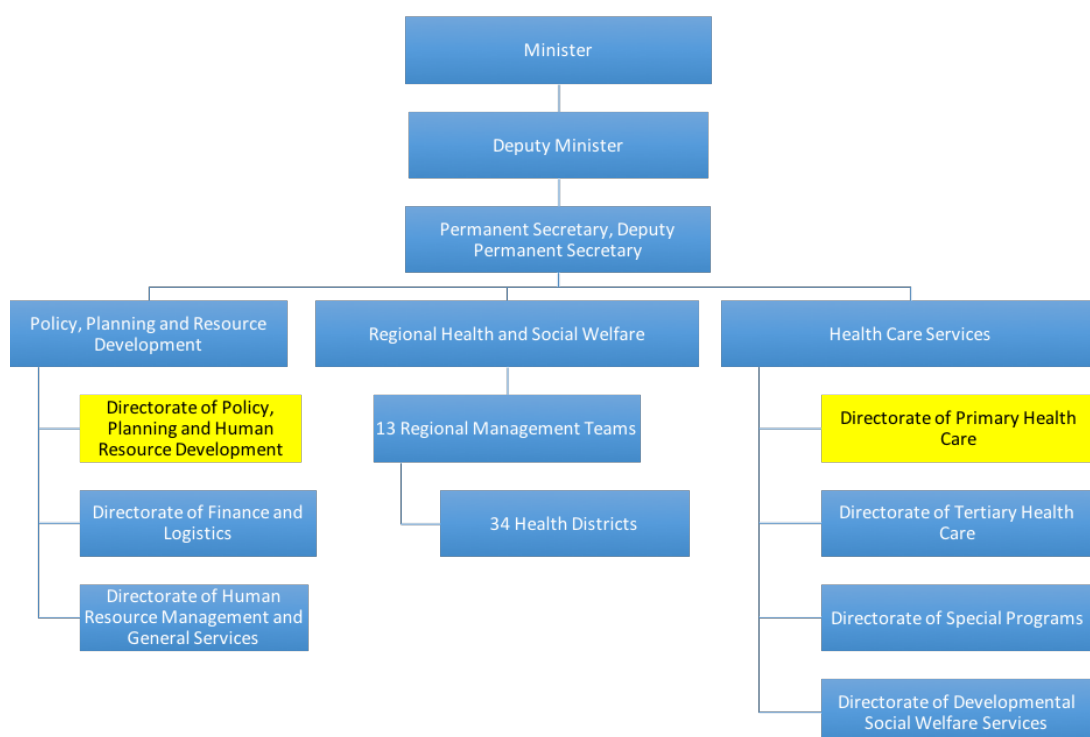
2003; Ministry of Health, 2007a; Ministry of Health, 2003). At a national level, the Ministry of Health develops and oversees national health policy (Ministry of Health and Health Systems 20/20, 2008). Health policy implementation and service provision are primarily managed at the level of the 13 administrative regions and 34 health districts (el Obeid et al., 2002; Ministry of Health, 2006; Ministry of Health, 2010).

At the national level, politically appointed Minister and accompanying Deputy Minister, who are both members of parliament, are the heads of the Ministry of Health. The Ministry of Health head office is responsible for policy formulation, strategic planning, legislation and regulation, monitoring, and overall coordination of the health sector (el Obeid et al., 2002). The national Ministry is made up of three main subdivisions: Policy, Planning and Resource Development; Regional Health and Social Welfare; and Health Care Services. These are further divided into eight functional directorates (See Figure 4.1).

The Namibian Government recognised HIV and AIDS as a national problem early on in the country's epidemic. As stated in chapter 1, the first case of AIDS in Namibia was detected in 1986 (Slotten, 1995). In 1989, while Namibia was still under the political administration of South Africa, a group of Namibian nurses and doctors formed an HIV and AIDS Advisory Committee (The Southern African Development Community (SADC) and MoHSS, 2010). According to a founding member of the Committee, who was interviewed for this thesis, the members came

together to plan for the response to HIV and AIDS in anticipation of Namibia's independence because "South Africa did not have a clear intervention plan".

Figure 4-1 Organisational Structure of Ministry of Health



In 1990, as the Namibian Government was putting its post-independence administrative structures in place, the newly elected first president, Sam Nujoma, made a public statement on the worrying impact of the HIV and AIDS for the country (Slotten, 1995). Since the initial policy statement on HIV and AIDS, the Namibian Government's response has been governed by several national strategies. The framework was

followed by three different Medium-Term Plans (MTPs) for HIV and AIDS specifically for the health sector, as administered by the Ministry of Health. The MTPs were in turn linked to the Namibian Government's overall economic development policies as represented by the National Development Plans (NDPs), which covered the same years as the MTPs (National Planning Commission, Office of the President, 2008, p. 188).

In 2007, while MTPIII was still in operation, a Policy on HIV and AIDS was approved by Parliament and launched by the President of Namibia. This policy set the foundation for the establishment of the National Strategic Framework for HIV and AIDS Response in Namibia 2010/11-2015/16 (NSF). Once it was promulgated, the NSF then replaced the MTPs as the short-term framework for HIV and AIDS (MoHSS: DSP, 2010). The NSF extended the earlier national HIV and AIDS policy frameworks by consolidating and expanding access to treatment with anti-retroviral medicines to those carrying HIV or AIDS.

In its policies for addressing HIV and AIDS, the Namibian Government recognises the important role that multiple stakeholders can play in reaching health objectives (Government of the Republic of Namibia, 2004; National Planning Commission, Office of the President, 2008). As was done in the MTPs, the Namibian government's policy for engaging with other stakeholders in efforts to address HIV and AIDS was also defined within the NSF (MoHSS: DSP, 2010). Thus, the NSF pulled together efforts of Government agencies, NGOs, faith-based

organisations, community-based organisations, the private sector and international development partners. To meet its stated Response Management objectives, a key element of the NSF was "to strengthen the capacity of the coordinating and management structures to improve effectiveness and increase efficiency (MoHSS: DSP, 2010, p. 9)."

Through the NSF, the Namibian Government also recognised the importance of developing sustainable financial resources for the various organisations involved in the country's multi-sector response to HIV and AIDS. In particular, the Namibian Government positioned itself as being committed at a policy level to building the capacity of and mobilising domestic financial resources for non-government stakeholders:

...special attention will be paid to develop the capacity of key stakeholders in critical areas including human resources, leadership and governance, monitoring and evaluation, planning and programming using evidence, results-based approaches, resources mobilisation and resources tracking. Innovative strategies for resources mobilisation in the country will be explored and Government will be encouraged to increase its funding for HIV and AIDS, strengthen public-private partnerships and reduce dependence on international resources (MoHSS: DSP, 2010, p. 10).

Thus through the NSF, the Namibian Government recognises 1) the importance of a multi-sector response to HIV and AIDS and 2) the importance of having a central body to coordinate the activities of relevant stakeholders.

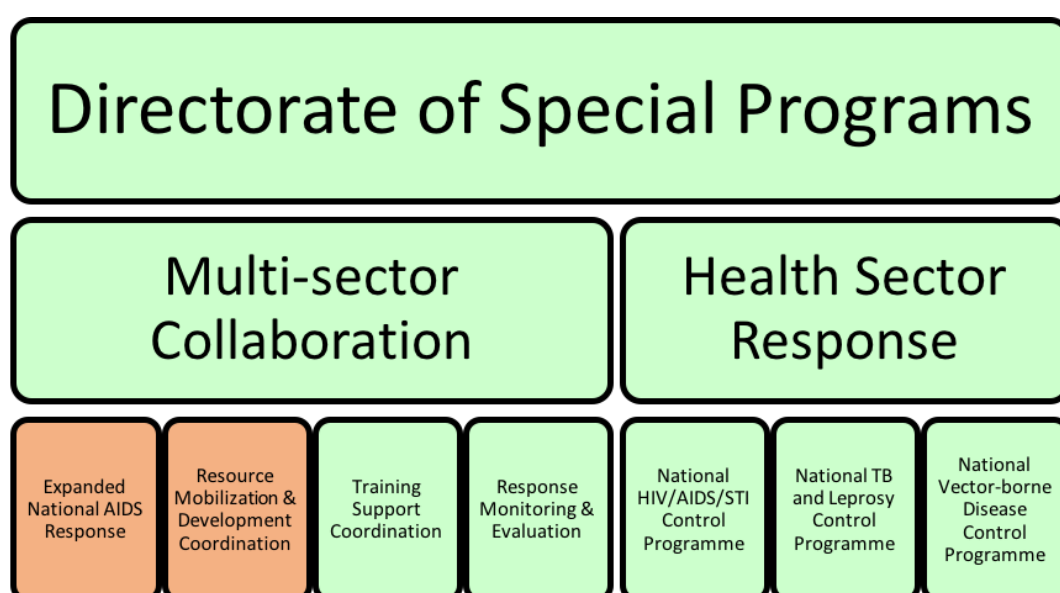
The Namibian Government was a direct recipient of both Global Fund and PEPFAR funding, primarily through the Ministry of Health of Health and Social Services (Office of the Inspector General, DHHS, 2013; The Global Fund, 2004; The Global Fund Office of the Inspector General, 2012). An essential element of the case study underlying this thesis is the Directorate of Special Programs (DSP) in the Ministry of Health. The DSP is one of the seven operational directorates within the Ministry of Health. It was established in 2002 to coordinate and monitor the Ministry of Health's national response to HIV and AIDS, TB and Malaria (GAMET and UNAIDS, 2006).

In 1990, the Namibian Government launched the National AIDS Control Program (NACP), which was placed within the Ministry of Health, to oversee its HIV and AIDS policy. In 1994 the National AIDS Control Program (NACP) was renamed the National AIDS Coordination Program (NACOP). The Namibian Cabinet then approved the restructuring of the Ministry of Health to make provision for the creation of the Directorate of Special Program (DSP). The DSP was established in 2004 to oversee the National AIDS Coordination Program (NACOP). NACOP was previously housed in the Primary Health Care Directorate of the Ministry of Health (MoHSS, 2008ab). The expanded staffing of the DSP was supposed to strengthen the Ministry of Health's capacity to co-

ordinate and manage the breadth of programmes and national HIV and AIDS policies (MoHSS: DSP, 2010).

In comparison to NACOP, the new mandate of the DSP was to mobilise financial resources for HIV and AIDS and manage them when they came into the Ministry (MoHSS: DSP, 2010, 2008a). Within the overall Ministry of Health structure of seven directorates, the mandate for donor engagement lies with the Directorate of Policy Planning and Human Resources Development (PPHRD). By establishing the DSP, Ministry of Health officials envisioned that it would serve as the structure that would coordinate and manage grants from donors such as the Global Fund and PEPFAR (MoHSS, 2008ab). As shown in figure 4.2, the DSP was established to have two main divisions: health sector response division and multi-sector response.

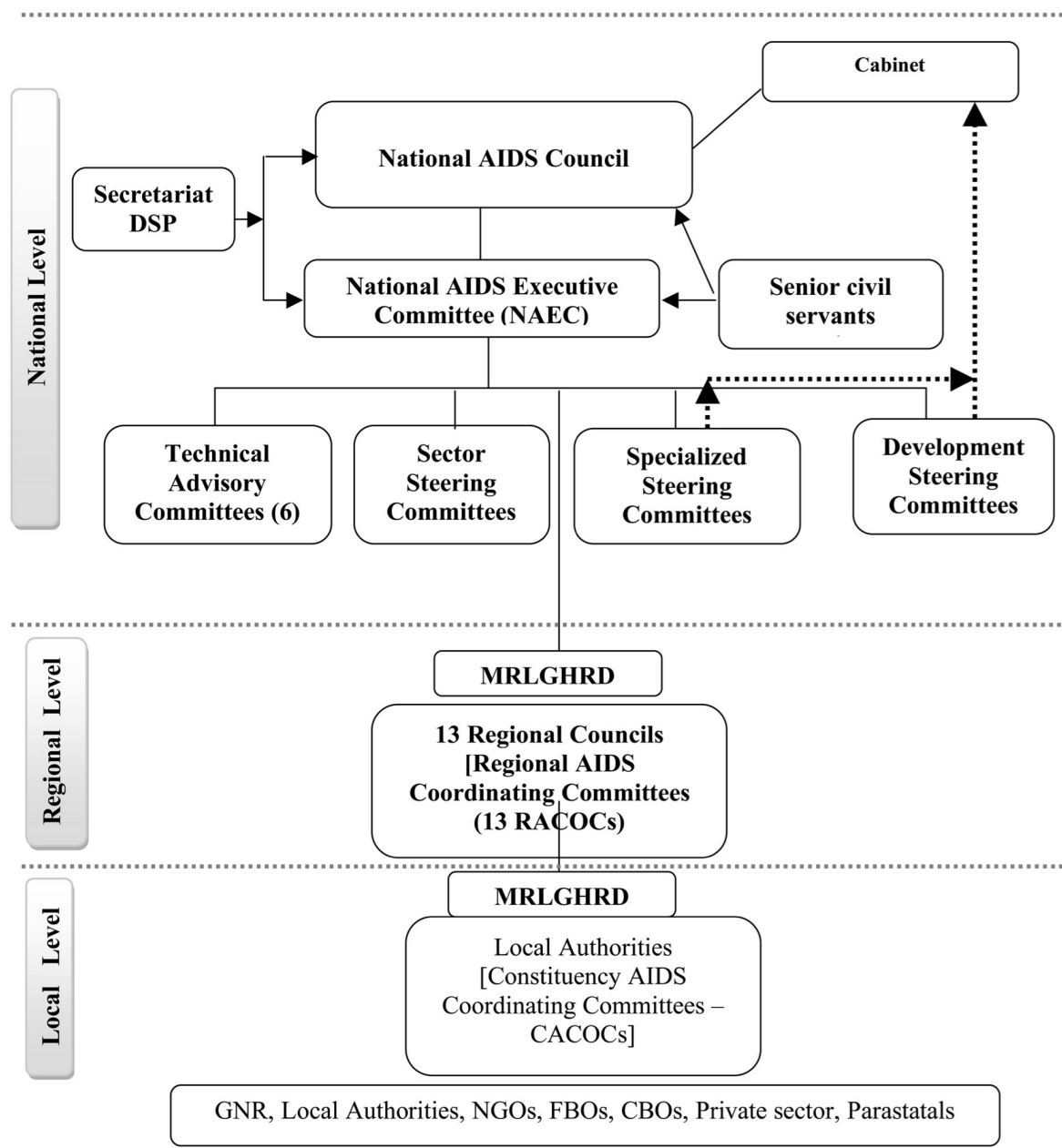
Figure 4-2 Ministry of Health, DSP Structure



The multi-sector response is broken down into three units: Resource Mobilisation and Development Cooperation (RM&DC); Expanded National AIDS Response Support (ENARS); and Response Monitoring and Evaluation (M&E). The NSF includes a National Coordination Framework, which "clarifies the mandate, roles and responsibilities, membership and the terms of reference for all the coordinating structures (MoHSS: DSP, 2010, p. 9)." The NSF is described as having developed with the recognition that the HIV and AIDS response requires "robust and sustained political commitment and leadership, availability of adequate resources, appropriate policies, and effective coordination of a multi-sectorial HIV and AIDS response" (MoHSS: DSP, 2010, p. 87). The Ministry of Health is meant to play a vital role in realising the objectives of the NSF.

As shown in Figure 4.3, the coordination of the Namibian HIV and AIDS response is also meant to take place at the national, sector, regional and community levels (MoHSS: DSP, 2010, p. 89). As with previous Government policies that defined national HIV and AIDS coordination in Namibia – such as the MTPs – the NSF positions the Ministry of Health as the overall steward of the country's response (MoHSS: DSP, 2010, 2008b). Specifically, the sub-division of Expanded National AIDS Response Support (ENARS) has the mandate to coordinate the multi-sector response on behalf of the Ministry of Health (MoHSS: DSP, 2010).

Figure 4-3 Namibian NSF HIV and AIDS Coordination Structures



Through National AIDS Executive Committee (NAEC), the DSP is mandated to coordinate all the various structures and agencies associated with meeting the objectives of the NSF. NAEC is meant “to work through technical advisory committees, sector steering committees, programme and specialised steering committees that may be established, and whose

mandate impact directly or indirectly on the national HIV and AIDS response (MoHSS: DSP, 2010)".

4.3 Namibia's Relationship with the Global Fund

When the Global Fund initiative was established, countries submitted proposals during an open call for proposals, in agreement with Global Fund guidelines and eligibility criteria. Each open call for proposals was called a Round of funding (The Global Fund, 2012a). Namibia's first successful approval for Global Fund resources was under the Round 2 call for proposals in 2002. In addition to a request for HIV and AIDS funding, Namibia's Round 2 grant proposal also included requests for grant financing towards TB and Malaria. The Round 2 project was titled, "Scaling up the fight against HIV/AIDS, TB & Malaria in Namibia" (The Global Fund, 2004).

As was the norm for Global Fund grants, Namibia's Round 2 grant was awarded for five years, but funding was disbursed, and the program was implemented in two phases (The Global Fund, 2012b). The implementation of Namibia's Round 2 grant was supposed to begin in January 2004 but started in January 2005 instead (NaCCATuM, 2007; The Global Fund, 2004). Phase 1 of the Round 2 grant began in January 2005 and ended in December 2006. Phase 2 started in January 2007 and

was supposed to come to an end on 31 December 2009 (NaCCATuM, 2009).

In 2008, in anticipation of the end of the Round 2 grant, Namibia applied for Round 8 funding for HIV and AIDS, but the proposal was not successful (NaCCATuM, 2009). In 2008, after the rejection of the Round 8 proposal, the country was positioning itself to apply for Round 9 when it was informed that it was eligible to apply for the Global Fund's newly established Rolling Continuation Channel (RCC) funding (NaCCATuM, 2009). Countries that apply for RCC funding have had to be invited to do so by the Global Fund based on a country's performances on its grant during the regular rounds of financing.

On the 1st of April 2009, the Ministry of Health received a letter from Global Fund Geneva, inviting the country to apply for Wave 7 of the RCC (Churchill, 2009). Namibia had first been offered to apply for RCC under the 6th Wave (September 2008). The country was dropped as part of Wave 6 because the verified implementation review period for Namibia's existing Round 2 grant was only 15 months instead of the preferred period of 18 months or more. As defined by the Global Fund under the RCC, Namibia had been successful in its implementation of the Round 2 grant, which then made it eligible for further support. According to the Wave 7 RCC invitation for the country to apply, Namibia had met the three main "RCC Qualification Factors" for the Round 2 grant (Churchill, 2009):

1. Sustained strong performance;
2. Evidence of potential for impact; and
3. Programmatic sustainability.

Following the Wave 7 invitation, Namibia was successful in its application for the RCC grant, which was meant to reflect a continued implementation of the Round 2 HIV and AIDS, TB, and Malaria grants (Bampoe, 2011). The start date for the RCC grant was July 2010, and it was expected to end in April 2016. At the time of data collection for this thesis, in early 2012, Namibia was in its second year of implementing the RCC grant (Bampoe, 2011). Table 4.1 shows the various amounts rewarded to Namibia for HIV and AIDS, TB, and Malaria for Round 2 and RCC grants.

Table 4-1 Global Fund Signed Amounts to Namibia, Round 2 and RCC: (MoHSS, 2011; The Global Fund Office of the Inspector General, 2012)

	Round 2 Signed amounts (USD) 5 Years	RCC Signed amounts (USD) 6 Years
HIV/AIDS	104,004,211	211,472,886
TB	1,294,610	1,776,976
Malaria	6,235,950	17,363,919
Total	111,534,771	230,613,781

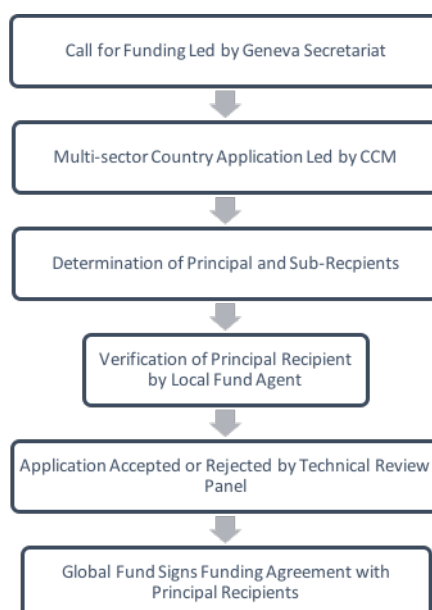
Table 4.1 shows that during Round 2 and RCC, most of Namibia's financial support from Global Fund was for HIV and AIDS. The amounts allocated to TB and Malaria interventions, respectively, were

significantly smaller. For Round 2, Namibia was awarded US\$104,004,211 for HIV/AIDS programs, as compared to US\$6.2 million for malaria and US\$1.3 million for TB. Under the RCC grant, Namibia was awarded US\$211,472,886 for HIV/AIDS, as compared to US\$17.4 million for malaria and US\$1.8 million for TB.

4.3.1 Agencies Associated with the Global Fund Programme in Namibia

The Global Fund Secretariat: The Global Fund Secretariat is the primary structure for the GHI's operations. It is based in Geneva, and in general terms, it is charged with "executing Board policies; resource mobilisation; providing strategic, policy, financial, legal and administrative support; and overseeing monitoring and evaluation (The Global Fund, 2001a)." For grant applications and management, it manages the grant portfolios by screening the proposals submitted and issuing instructions on the disbursement of funds to recipients and implementing the performance-based monitoring functions of the grants." All the Secretariat staff is based in Geneva (Garmaise and Greenall, 2008; Riddell, 2007).

Figure 4-4 Global Fund Proposal Process

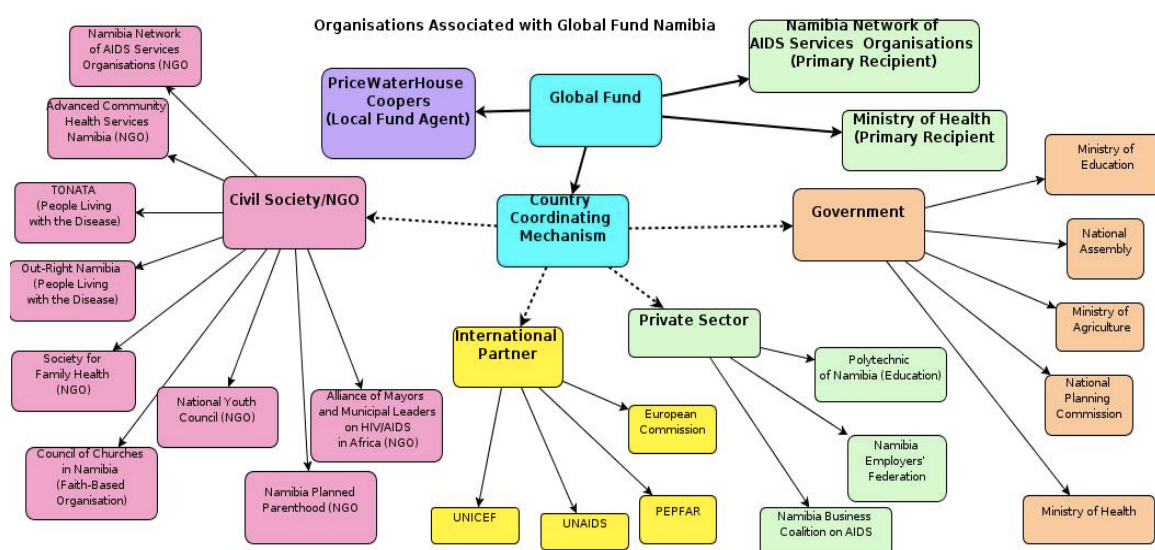


The Country Coordinating Mechanism: The Global Fund requires government and non-government stakeholders at the country level to define a mechanism for the coordination of their joint efforts around Global Fund financing (The Global Fund, 2013b). To meet these goals, the Global Fund at the onset of its establishment developed guidelines for the mechanism, which it refers to as the Country Coordination Mechanism (CCM). In 2002, Namibia established a CCM, which it called the Namibia Coordinating Committee for HIV/AIDS, Tuberculosis and Malaria (NaCCATuM). In describing the CCM for Namibia, the acronyms NaCCATuM and CCM are used interchangeably within the thesis.

In Namibia, the exact members of the CCM have changed over the lifetime of Global Fund operations in Namibia, but they have for the most proportionally represent the same type of organisations. As Figure

4.5 shows, the members of the Namibian CCM can be grouped into four main categories: government agencies, civil society, international development institutions, and private entities (The Global Fund Office of the Inspector General, 2012).

Figure 4-5 NaCCATuM Members: (The Global Fund Office of the Inspector General, 2012)



The Technical Review Panel: The grant proposal that is submitted to the Global Fund Secretariat by a CCM (or its equivalent) are passed on to the Technical Review Panel (TRP) if they are deemed to meet the guidelines laid out by the Secretariat (The Global Fund, 2013c). The TRP is “an independent group of international experts in the three diseases and cross-cutting issues such as health systems.” They meet regularly to review proposals, and then provide funding recommendations to the

Global Fund Board on who needs to receive funding (The Global Fund, 2013c).

Principal Recipient: The legal grant agreement to a country is signed between the Global Fund and a Principal Recipient. The recipient is an entity nominated by the CCM to receive the Global Fund finances directly and then use the funding to implement the programs described in the application or pass the funding on to other organisations (sub-recipients) who provide the services (The Global Fund, 2007).” As described within Global Fund guidelines, the role of the PR is to “directly receive the funding approved by the Global Fund Board and manage its implementation on a day-to-day basis on behalf of the CCM (The Global Fund, 2011b, p. 7)”. In Namibia, the Ministry of Health was the sole PR to the Global Fund grant under Round 2. For the RCC grant, the Namibian Network of AIDS Services Organisations (NANASO) was added as a second PR (NaCCATuM, 2009, 2007).

Sub-recipients: Before NANASO became a PR, the Ministry of Health served a PR to all SRs in Namibia, ranging from private, government to civil society organisations. With the RCC funding, NANASO became the PR for all civil society groups funded by Global Fund in Namibia (NaCCATuM, 2009). The Ministry of Health remained the PR for all other SRs. In Namibia, respondents also frequently referred to SRs as individual recipients (IRs). For consistency with existing Global Fund literature, this thesis uses the term SRs. Figure 4.5

shows the Ministry of Health and NANASO in association with all the other key stakeholders of the Global Fund grants in Namibia.

The RCC work plan identified civil society organisations as being essential to the HIV and AIDS response in Namibia particularly regarding community-based health care and support of people living with HIV (PLHV). The selection of NANASO as a second PR to the HIV and AIDS RCC grant to oversee the activities of civil society organisations was intended to strengthen the collaboration and coordination of CSOs involved in providing HIV and AIDS interventions in Namibia.

When Namibia applied for the RCC grant, the HIV and AIDS grant was classified as performing very well by the Global Fund and had been assigned a performance of A- by the GHI. Within the RCC application for Round 2, the Ministry of Health was given credit for effectively managing the work of nearly 30 individual Sub-Recipients (SRs) during Round 2 (RCC application). In total, the Ministry of Health had 19 SRs and seven Sub-SRs. The civil society SRs were selected to undertake the majority of implementation at the community level and for the primarily affected populations.

Local Fund Agent: Since the Global Fund defines itself as a non-implementing agency, it has no country presence of staff (The Global Fund, 2013a, 2001b). For financial systems for accountability at the local level, the Global Fund contracts a firm to act as Local Fund Agent (LFA).

The two primary responsibilities of the LFA as defined within the Global Fund Handbook are to provide recommendations on the capacity of the entities chosen to act as PRs/SRs to manage Global Fund resources. The LFA is also supposed to give recommendations on the soundness of the disbursement requests made by the PRs and be the first to evaluate the results reports before PRs submit them to the Global Fund Secretariat (The Global Fund, 2012b). For the Round 2 and RCC grants to Namibia, the Namibian office of the international accounting firm PriceWaterhouseCoopers (PWC) was contracted to serve as the LFA for the country (The Global Fund Office of the Inspector General, 2012).

4.4 Namibia's Relationship with PEPFAR Funding

Namibia was a recipient of the first two rounds of PEPFAR bulk funding, which were authorised by the United States Congress in 2003 and 2008 and identified as PEPFAR phase 1 and 2 (Office of the Inspector General, USAID, 2011). Regarding the countries that have received PEPFAR funds, Phase 1 had 15 focus countries that received most of the money, and a little over 30 other countries, which received smaller amounts (Kaiser Family Foundation, 2012). Primarily due to its high HIV and AIDS prevalence, Namibia was chosen as one of the 15 focus countries under PEPFAR Phase 1. Of the 15 focus countries, 14 of them were in Sub-Saharan Africa, and the other one was Vietnam (108th USA

Congress, 2003; 110th USA Congress, 2008). During PEPFAR phase 1, between 2004 and 2008, funding to Namibia through the initiative increased steadily every year (PEPFAR, 2012, 2011). In the U.S Government's 2004 fiscal year, Namibia received US\$24.5 million of PEPFAR funds, it then received US\$42.5 million in 2005, US\$57.3 million in 2006, US\$91.2 million in 2007, and US\$108.9 in 2008 (Kaiser Family Foundation, 2011).

Chapter one shows that at the global level, the PEPFAR initiative was structured to facilitate joint planning and decision-making between US development agencies. In its first 5-year authorization, PEPFAR started off as an emergency response to HIV and AIDS. It sought to support national programs to scale up interventions rapidly. In its second 5-year authorization, it had much more of a focus on sustainability and health systems strengthening. Under phase 2 of PEPFAR funding, the initiative removed the concept of "focus" countries and countries were considered for the financing by whether they were viewed as having a high or low burden of HIV and AIDS. Namibia was classified as a high burden country and remained in the top 10 recipients of PEPFAR funding as part of Phase 2 funding (110th USA Congress, 2008; Kaiser Family Foundation, 2012).

In 2009, the Namibian Government and PEPFAR signed a Partnership Agreement, which led to the formation of the PEPFAR Steering Committee in the Country (PEPFAR, 2011). According to

Holmes et al. (2012), the partnership frameworks "map out five-year strategic alliances between PEPFAR and governments, Global Fund, and other in-country partners. According to a PEPFAR representative in Namibia, the Partnership Agreement allowed the country's program to start looking at sustainability and also allow recipients to begin managing a transition away from PEPFAR funding so that the country can achieve its response way long after PEPFAR or Global Fund or other donors have left Namibia. In 2012 when data for this thesis was collected, Namibia was in its 4th year of implementing interventions under Phase 2 of PEPFAR funding (Holmes et al., 2012; PEPFAR Namibia, 2012).

4.4.1 Agencies Associated with the PEPFAR Programme in Namibia

As described in chapter one, PEPFAR is a bilateral initiative. It came about through a decision by the U.S Government on how it wanted to contribute to tackling HIV and AIDS at the global level. For PEPFAR funding to initially become available to be spent on a global scale, the money first had to be authorised by the U.S Congress. The initial authorization also came with specific guidelines on how PEPFAR funding would be approved, planned for, and tracked at both the global and country levels (108th USA Congress, 2003; 110th USA Congress, 2008).

Office of the Global AIDS Coordinator: On a global level, PEPFAR activities were established to be supervised by the Office of the US Global AIDS Coordinator (OGAC) in Washington D.C, which reports to the

President and the Congress of the USA (108th USA Congress, 2003).

Among its various responsibilities for managing the PEPFAR initiative, OGAC was primarily established to “oversee the program and policy coordination among all the US Government agencies and their appropriate counterparts so as to avoid duplication of efforts” (Office of the U.S. Global AIDS Coordinator (OGAC), 2004).

PEPFAR Implementing Partners: From its establishment, most PEPFAR funding at the international level was channelled through agencies already associated with the U.S Government (Fan et al., 2013; Oomman et al., 2008; United States Department of State and the Broadcasting Board of Governors Office of Inspector General, 2010b). Within the first congressional approval for PEPFAR, the U.S Government agencies that were designated as funding recipients were collectively referred to as PEPFAR Implementing Partners (Office of the U.S. Global AIDS Coordinator, 2013). PEPFAR funding was then allocated to sub-recipients associated with the primary partner as appropriate (Office of the U.S. Global AIDS Coordinator, 2013).

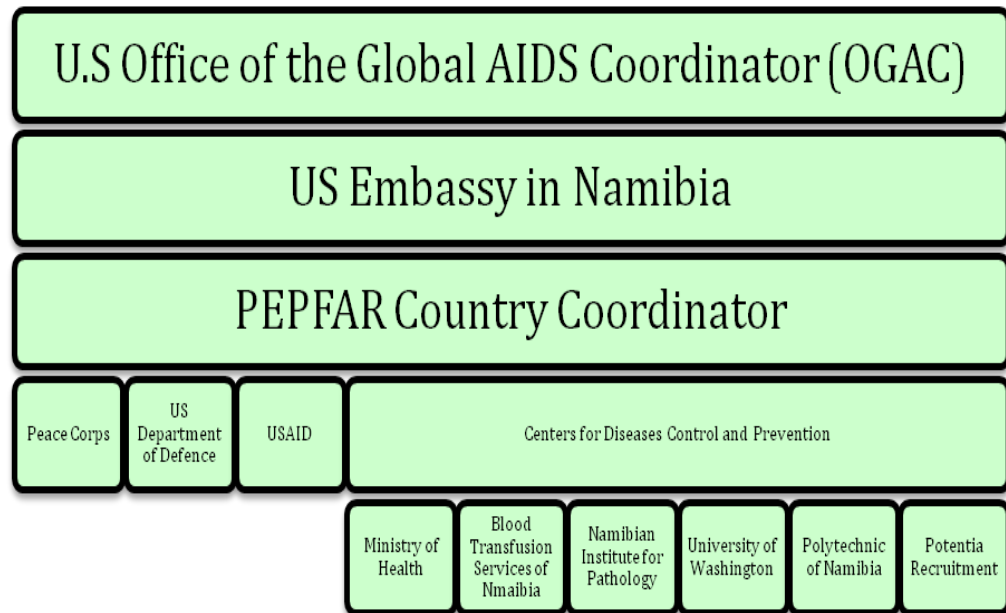
Primary Implementing Country Partners: At the national level, the U.S Government organisations that were designated as PEPFAR implementing partners varied between countries. As part of the authorization for PEPFAR Phase 1, agencies were initially assigned to work in countries with which they already had a relationship (108th USA Congress, 2003). At the national level, PEPFAR funds are allocated to

"Primary Partners" that ranged from the government, private sector, and local and international NGOs (Hanefeld, 2010; Oomman et al., 2008).

During both PEPFAR phase 1 and 2, there were five central U.S Government implementing partners for the PEPFAR initiative in Namibia. These were the Department of State, the Department of Defense, Peace Corps, United States Agency for International Development (USAID), and the U.S Centres for Diseases Control (CDC) (PEPFAR, 2011; PEPFAR Namibia, 2012).

Local Implementing Partners: In Namibia, each of the five U.S Government implementing partners implemented their interventions and also allocated funding to local implementing partners (PEPFAR Namibia, 2012; USAID and TeamSTAR, 2006). Figure 4.7 shows the five Primary Country Implementing Partner in Namibia and their Local Implementing Partners.

Figure 4-6 Partners in Relation to PEPFAR and CDC in Namibia



Each of the five US Government agencies associated with PEPFAR funds in Namibia was country versions of larger development organisations that are governed from the USA. The country offices were accountable to their headquarters in the USA, which in turn directly reported to the OGAC office for their PEPFAR activities. For instance, CDC Namibia reported to the CDC headquarters in Atlanta, not to OGAC in Washington D.C. For PEPFAR, the CDC headquarters was in turn accountable to the U.S Government's Department of Health and Services (HHS) (Department of Health and Human Services, Office of the Inspector General, 2013; PEPFAR, 2011).

The general international operations of CDC both within the USA and abroad are premised on its working in conjunction with existing health sector agencies. Thus in the chain of PEPFAR funding, the CDC

Namibia office was a sub-recipient of the CDC headquarters in Atlanta, and the Ministry of Health was one of CDC Namibia's sub-recipients in the country. During both phase 1 and phase 2 of PEPFAR funding to Namibia, the relationship between CDC and the Ministry of Health was governed by a financing mechanism called the Cooperative Agreement (CoAg). The CoAgs defined the general plan for the partnership between CDC and the Ministry of Health over the two 5-year periods covered by the PEPFAR authorizations (Department of Health and Human Services, Office of the Inspector General, 2012, p. 1).

As described within their cooperative agreement (CoAG) for PEPFAR phase 1, the purpose of the Ministry of Health's relation with CDC was for "Ministry to implement a coordinated national response to the HIV/AIDS epidemic"(Department of Health and Human Services, Office of the Inspector General, 2013). The goals of the second CoAg between CDC and the Ministry of Health are laid out as being “to strengthen the Ministry’s capacity in the following three areas (Department of Health and Human Services, Office of the Inspector General, 2013, p. 1):

1. Deliver improved voluntary counselling and testing; support prevention of mother-to-child transmission of HIV;
2. Perform HIV/AIDS-related surveillance; and
3. Provide comprehensive HIV/AIDS care, including antiretroviral therapy.

At the global level, CDC had the mandate to operate on a broad range of health issues on behalf of the U.S Government. As one of the

Implementation Partners under PEPFAR, CDC has had a leadership role in the areas of implementing HIV/AIDS programs, program monitoring, impact evaluation, and operations research (U.S Centers for Disease Control and Prevention (CDC), 2004). CDC was designated to implement the PEPFAR initiative through its Global HIV/AIDS Program. Its functions were defined as “working with ministries of health and other in-country partners to combat HIV/AIDS by strengthening health systems and building sustainable HIV/AIDS programs” (United States Department of State and the Broadcasting Board of Governors Office of Inspector General, 2010a).

Although bulk PEPFAR funding for both Phase 1 and Phase 2 was each approved to cover five years, the first PEPFAR legislation mandated that funding to be spent on the implementation of activities had to be approved every year (108th USA Congress, 2003). Every PEPFAR year, representatives at the U.S headquarters of PEPFAR implementing partners receive a budget from the Office of the Global AIDS Coordinator (OGAC), indicating the amount of funding that was collectively available to them. Several committees, made up of representatives from each of the main PEPFAR Implementing agencies, then made decisions on how to allocate the funding across their operations in the various countries. OGAC used this plan to notify Congress on how PEPFAR funds will be utilised for a given year (Fan et al., 2013).

Figure 4-7 Overall Structure of PEPFAR Partners



At the country level, the implementing US Development organisations apply for the funding that is made available to OGAC through an annual process called the Country Operational Plan (COP). As defined in the PEPFAR Country Operational Plan Guidelines, the COP "is the vehicle for documenting the U.S Governments annual investments and anticipated results in HIV/AIDS". It enabled U.S Government agencies to provide a "single supporting narrative" to describe their PEPFAR management strategy for a given country (PEPFAR, 2011, p. 7). Not all countries, which receive PEPFAR funds, are required to submit a COP. The need for a COP depended on the size of the PEPFAR program within a country. For the budget year starting in 2012, only 34 out of the 124 recipients needed to submit a COP (PEPFAR, 2011). As one of the original focus countries, Namibia was required to submit a COP for each of the years it has received PEPFAR funds.

In Namibia, the COP processes for phase one and two were driven by the five PEPFAR implementing agencies through the Country Coordinator's Office. Once COP had been approved by both the Country Coordinator's Office and the OGAC headquarters, only then was PEPFAR funding potentially available to in-country sub-recipients such as the Ministry of Health. By design of the U.S Congress, the day-to-day implementation and oversight of PEPFAR funding at the country level were the responsibility of U.S Government agencies (108th USA Congress, 2003).

4.5 Global Fund and PEPFAR Health Systems Implications for Namibia

Since the country's independence in 1990, Namibia has had one of the highest total government health expenditures per capita and the lowest out-of-pocket payments for patients in Africa (Leive and Xu, 2008; Schmidt, 2009). Financial ability to pay does not, however, correlate with adequate provision of health services. Namibia's performance for Disability Adjusted Life Expectancy (DALE) is often much lower than what would be expected for the level of financial resources spent on health in the country (European Economic Fund, 2008; Zere et al., 2006). The Namibian health system does not suffer from complete inadequacy of financial resources, it appears more to suffer from the inefficient and inequitable allocation and utilisation of resources (MoHSS, 2008ab).

Rural populations are in particular more likely to be poor than their urban counterparts (Kaapama, 2007; Schmidt, 2009). Inadequate human resources capacity was perceived as one of the key issues limiting the rapid scale-up of HIV and AIDS services in Namibia when the country started receiving funding from the Global Fund and PEPFAR (El Obeid, 2001; McCourt and Awases, 2007). For purposes of scaling up HIV and AIDS services, government-run health facilities had a general shortage of skilled personnel such as doctors, senior managers, and other specialists (El Obeid, 2001). In the year 2000, for Namibia as a whole,

there were about 7,500 people per public service doctor, and about 950 people per registered nurse (El Obeid, 2001). The country's health worker capacity at three doctors per 1000 people was just above the WHO benchmark of 2.5 physicians per 1000 people (Callaghan et al., 2010; Lipinge et al., 2006; World Health Organization, 2007). However, as with many socio-demographic factors in Namibia, significant disparities in health workers existed between urban and rural areas (El Obeid, 2001; Lipinge et al., 2006).

There were various factors, which defined the health worker situation in Namibia when Global Fund and PEPFAR resources arrived in the country. Until the first medical school was established in Namibia in 2011, all medical related training aside from nursing, radiography, social work and pre-medical training, had to be conducted outside the country. There was a high attrition of public workers from the public sector to the private sector where remuneration packages were perceived as more attractive (McCourt and Awases, 2007; MoHSS, 2008ab; MoHSS and CDC, 2010). Human resources attrition in the public sector adversely impacts on the scope and quality of health care, and this in turn negatively affects the poorest of the poor. The resulting high workload on remaining staff aggravated work-related stress and resulted in the poor attitudes towards clients, which in turn influences service acceptability and use (MoHSS, 2008ab). Scale-up of HIV and AIDS services was

specifically hampered by the scarcity of professional staff skilled the management of clinical treatment (MoHSS, 2008ab; NaCCATuM, 2009).

A 2008 Review of Health and Social Services in Namibia, however, shows that the disparity in health worker capacity between the public and private sectors, and between the urban and rural areas that existed before the two initiatives arrived, was persistent in the presence of Global Fund and PEPFAR support (MoHSS, 2008ab). For example, 28 percent of Namibia's physicians were found to work in the public sector, while 72 percent were in the private sector. Regarding the rural-urban disparity, only 24 percent of doctors in Namibia were found to work in rural areas as compared to 76 percent in urban areas (MoHSS, 2008ab). The 2008 review also highlighted challenges under Governance such as weaknesses in leadership; duplication of structures and functions (including health information systems); weak coordination of donor activities; and limited involvement of non-Ministry stakeholders in policy formulation (MoHSS, 2008ab).

In August 2012, the second President of Namibia appointed a Commission of Inquiry “to look into the activities, affairs, management, and operations of the Ministry of Health and Social Services (MoHSS) (Presidential Commission of Inquiry: MoHSS, 2013, p. 4).” The Inquiry evaluated the quality of infrastructure, the skills and availability of human resources; the status and availability of medicines and medical equipment; maternal and child health; and general conduct of health

professionals (Presidential Commission of Inquiry: MoHSS, 2013).

According to the Commission's report, the Ministry of Health did well in stocking and making available medicinal and treatment supplies at the clinical level. For instance, the Commission found that the availability of medicines in public health facilities was excellent, with stock levels of above (CMS) (Presidential Commission of Inquiry: MoHSS, 2013).

For all the other issues that the Commission evaluated, the Ministry was found to have significant weaknesses and challenges (Presidential Commission of Inquiry: MoHSS, 2013). According to the report by the Presidential Commission, the Ministry of Health's greatest challenge at the national level was inadequate human resources, a problem that was then found to be directly tied to deficiencies in the Ministry of Health operations as a whole. Rural health clinics and health centres, in particular, were found to be inadequately staffed both for the number of employees and the appropriate skill sets required to provide adequate health services (El Obeid, 2001; MoHSS, 2008ab; Presidential Commission of Inquiry: MoHSS, 2013). Many health facilities were, therefore, overcrowded, and the quality of patient care was often lacking in public health facilities (Presidential Commission of Inquiry: MoHSS, 2013, p. iv).

The Commission found "an acute and critical shortage of health professionals such as doctors, nurses, pharmacist and allied health practitioners in the country (Presidential Commission of Inquiry: MoHSS,

2013, p. iv)”. The Presidential Commission argued that the identified weaknesses made it difficult for the Ministry of Health to provide consistent quality health services. There were a lot of health workers hired and trained on how to provide HIV and AIDS health services as result of GHI funding. In the country's application for HIV RCC support, the Namibian applications acknowledged that it would be crucial to sustaining the human resources capacity that was created with the assistance of the Global Fund and PEPFAR (NaCCATuM, 2009). The demand for ART for adults and children with HIV infection will most likely continue to grow (Hecht et al., 2010). The long-term implications of the current global HIV situation are the need for financing and the need for health systems that can not only retain those already on treatment but also absorb the new infections. HIV and AIDS will remain a challenge to Namibia for a while yet (NaCCATuM, 2009).

5. Financial Flows

5.1 Introduction

In chapter one this thesis defined what is meant by country ownership and its implications for institutional autonomy. Using these definitions, chapter one also justified the focus of this thesis on the Ministry of Health due to its mandated role to steer the Namibian public health sector's HIV and AIDS response. Chapter two then examined the extent to which the issues of country ownership and institutional autonomy have been taken into account in the academic literature on the country-specific interactions of the Global Fund and PEPFAR. The chapter criticised the bulk of the research for framing the issue of ownership from the perspective of seeking to prove the effectiveness of the HIV and AIDS global health initiatives (GHIs). In comparison, this thesis examines the ways in which HIV and AIDS GHIs impact country ownership of health systems.

In the last chapter, this thesis then provided the background on Namibia's health policy context for HIV and AIDS both independent of and in its engagement with Global Fund and PEPFAR assistance. This chapter examines the structures and processes for financial disbursements that governed the Ministry of Health engagement with the Global Fund and PEPFAR at both the increase and decline of funding to Namibia.

5.2 Initial Global Fund Financial Flows

When the Global Fund was first established, its guidelines stated that all PR's were supposed to have "certain minimum capacities" in five functional areas, namely: Financial Management and Systems; Program Management; Sub-recipient Management; Pharmaceutical and Health Production Management; and Monitoring and Evaluation (The Global Fund, 2001). The Ministry of Health proved these minimum capacities, which then then enabled the country to be approved for Round 2 funding. Grant documents for the Round 2 grant show, however, that although Namibia was successful in its application for the funding in 2002, the country only received its first disbursement in 2004 (The Global Fund, 2004). As defined in the Grant Agreement for Round 2, Namibia had to demonstrate specific grant management capacities before the Global Fund made its first disbursement to the country (The Global Fund, 2004).

Rather than hiring people to carry out these responsibilities and then housing them within the Ministry of Health, a consortium between Ministry, the Royal Tropical Institute (KIT) and the Malaria Consortium of Liverpool was first established to meet the grant management capacities expected of a PR (NaCCATuM, 2009). The Ministry of Health and the two agencies formed a consortium that recruited and managed all the workers in Namibia who were employed to work on interventions

funded with Global Fund money (NaCCATuM, 2009). Then, in 2006, money from the Global Fund to Namibia began to be managed through a Programme Management Unit (PMU), which was established to work alongside the DSP. As described by interview respondents from both the DSP and the PMU, the PMU was created to serve as a contractor to the Ministry of Health.

A respondent from the Operations Management Division of the PMU described the unit as existing to meet the reporting requirements of the Global Fund in the following ways:

You need somebody to make the financial reports and to do the accountability for the GF funding going into the ART program...You need those people. Otherwise, you don't get the reports...these individuals are important to the donor relationship because there is quite a strong link between M&E and the donor funding in terms of proving performance and enabling the next disbursements (Global Fund Namibia PMU).

According to the respondents representing the PMU, the Ministry of Health was responsible for the Global Fund money in the country at a high level, but the PMU was established to carry out the management functions of the grants on a day-to-day basis. Respondents associated with the Ministry of Health, on the other hand, understood the establishment of the PMU as a general requirement for receiving a Global Fund support.

A respondent from the DSP therefore characterised the reasons for the establishment of the PMU in the following way:

That is the way that the Global Fund wants its money to be managed, and this is how it works in each country...Global Fund does not want the money to go into the coffers of the Ministry. The PMU is meant to administer the funds on behalf of the Ministry (Ministry of Health, DSP).

The respondent from DSP perceived the Ministry of Health and Namibia as grant recipients of the Global Fund as having to establish the PMU for the country to receive money.

Within the initial Round 2 grant agreement between the Ministry of Health and Global Fund Geneva, the decision was made that Namibia would request disbursements on its grants on a quarterly basis (The Global Fund, 2004). The role of the PMU was to accept; assess; and process the disbursement requests that the country made from the Global Fund; as well as manage and administer the sub- recipients for funding from the PR. In reflecting on their role in the flow of Global Fund money in Namibia, PMU staff interviewed for this research perceived themselves as working on behalf of the Ministry of Health:

The PR is being assisted by the PMU, making sure that the money is available in the country in the time it is supposed to be here; that the reports are given to the Global Fund by PR. The Global Fund will never demand anything from PMU, in fact, they always refer to the PR, which is correct because they are in a relationship with PR (Global Fund Namibia PMU).

Although the PMU was responsible for the administrative management and processing of the disbursement requests, both PMU and DSP respondents were quick to point out that the Ministry of Health always approved the final requests that the PMU made to the Global

Fund Secretariat. As reported by a respondent who managed finances in DSP, when the Ministry of Health was first approved for the Global Fund Round 2 grant, it established a bank account for Global Fund money. Thus when the Global Fund approved a disbursement request and sent money to Namibia, the money was put into this bank account. It was from this bank account that the Ministry of Health made payments to sub-recipients. Although the bank account belonged to the Ministry of Health as a whole, DSP was given the overall responsibility for managing the flow of money in and out of the Global Fund-related bank account. With approval from the DSP financial officers, the PMU then made funding disbursements to sub-recipients.

DSP respondents also perceived the PMU as acting on behalf of the Ministry of Health in relation to managing its relationship with Global Fund grant sub-recipients:

The sub-recipients submit quarterly cash forecasts to PMU. The PMU looks at the cash forecasts and decides if they are accurate and realistic. The finance staff of the PMU sometimes make some adjustments to the forecasts, or they go back to the recipients for more queries. When the PMU is satisfied with the sub-recipient's forecasts, it then makes a request to the Ministry of Health to release money to the sub-recipients (Ministry of Health, DSP)

As described by a finance officer within the DSP, the Ministry of Health had a distant and arms-length relationship to the sub-recipients. If the Ministry of Health was unhappy with something within the reports or

activities of the sub-recipients, they told the PMU, and then the PMU would engage with the sub-recipients.

As described by various interviewees, the PMU served as the administrative intermediary in two different capacities. In the first instance, it was established to act as a liaison between the Ministry of Health and the Global Fund headquarters in Geneva (The Global Fund, 2007, 2001b). In the second instance, the PMU was established to serve as a liaison between the Ministry of Health as the PR, and the sub-recipients of the Global Fund grant. Respondents from the DSP argued that because money from the Global Fund was disbursed on a quarterly basis, they were able to track how much money they had available at a given time.

5.3 Evolving Ownership of Global Fund Finances

In the regular rounds of Global Fund grants, the CCMs applied for 3 to 5 years of funding. However, even after a grant application was successful, funding was allocated according to two different stages, phase 1 and phase 2. Because the Global Fund was set up to use performance-based financing, the CCMs (and associated country recipients) had to demonstrate that a particular grant was achieving initial targets for beneficiaries to be approved for more funding under Phase 2 of funding for 5-years (The Global Fund, 2001). Under the Rolling Continuation

Channel (RCC), which the Global Fund introduced after its post-2008 change in strategy, grants were approved for six years. Based on the demonstration of progress towards grant targets in the first three years, the Global Fund then committed to funding recipients for a further three years (Churchill, 2009).

As told by respondents from both the Ministry of Health and PMU, the funding commitments and disbursements for Round 2 HIV and AIDS funding went as agreed with the Global Fund in the grant agreement. As was expected, during Round 2, the Global Fund made disbursements to Namibia on a quarterly basis soon after requests have been made by the PMU on behalf of recipients. The Global Fund also apparently made payments to the exact value sought by the county programmes. Respondents from both the DSP and the PMU, however, indicated that Global Fund disbursements were less reliable under the RCC grant.

As reported by Ministry of Health and PMU respondents, payments on the RCC grant frequently came much later than during the period for which they had been requested. In February 2012, a respondent from the PMU explained that given that the first phase of the RCC grant had officially commenced in July 2010, the PR should have received approximately 80% of the total disbursements due, but the Ministry of Health had received only 39% of the expected payments:

They used to be done in time. You know, you would put in cash forecast every six months, and it would usually be approved within three months, between 2005 and 2010. Then it just nose-dived since

then...We are now into the final quarter of the first two years of RCC, so we are into one year nine months, and we should have had four disbursements. I think we just received the second, one a month ago (Ministry of Health, DSP).

Reflecting on this issue of late disbursement, in response to a request for payment that the Ministry of Health made in September 2011, the Global Fund sent the PR a letter dated 29th of February 2012 (Masanhu, 2012). The Global Fund confirmed that it decided on a disbursement amount of US\$9.4 million for the period of October 2011-March 2012, rather than the US\$17.2 million as had been requested by the country, for several reasons. One of the primary reasons given in the letter was that the Global Fund had found that the PRs and the SRs had a combined cash balance of more than US\$6 million U.S dollars when the request for disbursements was made. In another letter dated the 7th March 2012, the Global Fund further argued that the cash balances were not in standing with performance-based funding grant rules:

With Performance Based Funding Model, grant performance, expenditure rates and cash balances are critical in influencing the disbursement decision. We note that with the RCC Round 2 HIV/AIDS grant, high-performance results are achieved with low expenditure; a combination that does not support the release of the amounts requested by the PR (Masanhu, 2012, p. 5).

Table 5.1 is a copy of the table given by the Global Fund to justify the conclusion that the PR and SRs kept large balances from one reporting period to another, and to demonstrate that the grants were still

performing well despite the delays in and reductions in requested disbursements.

Table 5-1 Namibia Disbursement Requests and Expenditures for Global Fund RCC Grant July 2010 to September 2011 (Masanhu, 2012, pp. 4–5)

Reporting Period	July-Sep 2010	Oct 2010 – March 2011	April 2011 to Sep 2011	Average
Approved budget	5,494,087	15,758,963	14,478,556	11,910,535
PR's Forecasted Amount	7,118,498	14,023,967	8,967,722	10,036,729
Programmatic results (gross)	90%	176%	252%	173%
Actual Expenditure (per semester)	2,022,679	10,684,840	2,109,789	4,939,103
Excess of forecast by PR compared to actual	252%	31%	325%	203%
PR's reported ending cash balances	12,794	8,291,095	5,219,637	4,507,842

The Global Fund's arguments for why disbursements were reduced or held back implied that because Namibian recipients had Global Fund money in their bank accounts, they did not need the money that they were requesting. Respondents from both the PMU and the DSP argued, however, that the Global Fund disbursements that were late or reduced put the Ministry of Health in a position that required it to hold seemingly large balances.

In a letter dated 05 April 2012, the Ministry of Health focused on reiterating why it had what could be perceived as having enough money (Kahuure, 2012a, p. 1):

As explained in our December 2011 management letter response, the PR made a decision to retain funds meant for reimbursement of ARVs due to uncertainty over the timing of the next disbursement. Money was set aside to enable the PR to meet commitments like, for example, staff salaries, on time.

In the letter from 05 April 2012, the Ministry of Health further argued that it was incorrect for the Global Fund to penalise the Ministry of Health for having surpassed its targets:

Programmatic results are not tied to Global Fund funding and ARVs are pre-finance. This analysis does not reflect the truth and unfairly puts the blame on the PR/MoHSS (Kahuure, 2012a, p. 4).

Further to the fact that HIV and AIDS results could not all be attributed to Global Fund support, respondents from PMU and DSP also argued that the demonstrated results were also due the fact the Ministry of Health continued to meet its reporting requirements to the Global Fund even though it was not receiving disbursements. Namibians were deemed as not needing the money if they submitted the reports; but were considered as being underperforming when they did not provide the reports (Kahuure, 2012a).

Communication to the Ministry of Health from the Global Fund Secretariat in Geneva indicated that the first RCC disbursement was delayed because the contracts between the PR and the Global Fund were not signed as soon as the grants had been awarded (Bampoe, 2011, p. 1). Respondents from the DSP and PMU agreed that Namibia had been required to conduct a salary survey as part of the RCC grant approval.

They, however, argued that even if delays in grant signing justified the delay in the first disbursement, they did not justify delays in subsequent disbursements; nor did the delays in grant signing justify the reductions in amounts once the payments were made.

Respondents from the Ministry of Health and PMU further argued that the Global Fund's inconsistent behaviour created uncertainty that made it difficult for the Ministry to implement activities under the RCC grant. The Ministry of Health expressed these sentiments in a letter sent to the Global Fund Geneva on the 16th of December 2011. The letter explained why the Ministry of Health had requested more money than that which the Global Fund perceived as justified (Kahuure, 2011):

Your analysis under 'Rationale for the disbursement recommendation' does not take into account that the spending for the period April to September 2011 was controlled (suppressed) to avoid running out of funds due to uncertainty over the time of receipt of the next disbursement from the Global Fund. As a result, the PR made a conscious decision to delay reimbursing the Central Medical Stores (CMS) for the ARVs procured. We explained this during the country team visit (November 01-04, 2011) and it was agreed that the PR should include the outstanding reimbursement in the September 2011 Progress Update and Disbursement Request (p. 1).

In another letter to the Global Fund dated 07 February 2012 (Kahuure, 2012a), the Ministry of Health also noted the Global had also had failed to inform Namibia in due time whether it would be receiving funding for the 3rd year of the first phase of RCC. According to the Ministry of Health, when the Global Fund Country Team visited Namibia in November 2011, they had stated that "the second commitment is just a

formality". Four months before the first two years of guaranteed funding coming to an end, the Ministry of Health had not yet received a commitment for the RCC HIV and AIDS grant for the period 01 July 2012 to 30 June 2013 (Kahuure, 2012b). The Ministry of Health further noted that the Global Fund had unilaterally rejected budget decisions that had been made in consultation between the two parties (Kahuure, 2012b, p. 2):

We wish to highlight that the PR submitted the final revised budget with proposed cuts from the PR's side, which is based on agreements reached through the teleconference with the GF Country Team (CT) on December 13, 2011. After that, the CT still proceeded unilaterally with budget reductions, which rendered recruitment for essential staff and the implementation of some M&E activities virtually impossible (Kahuure, 2012b, p. 2).

Respondents from both the DSP and the PMU also perceived the Global Fund headquarters as refusing to take accountability for how its decisions negatively impacted on the implementation of the RCC grant. Respondents in Namibia viewed the Global Fund as not having been transparent about the way it was affected by the Global Financial Crisis that started in 2008. They believed that Global Fund found itself in a situation where it did not have enough money but failed to take accountability and be honest with recipients. Instead, it sought to blame them:

Since the financial crisis in 2008, donor funding has fallen drastically, and I am not sure they have got a clue what they are doing anymore, other than just trying to be awkward. They are trying at the moment to save money left, right and centre, and they

are not going about it, in my view, in the correct fashion. Rather than trusting PRs and saying to them, they are trying their hardest to say; you are misusing funds, so, therefore, we are not going to give you any more (Ministry of Health, DSP).

In a letter dated the 7th of March 2012, the Global Fund argued that "contradictions" concerning balances versus disbursements "seem to exemplify a weakness in communication with the Program Management Unit" (Eldon-Edington, 2012, p. 2). DSP and PMU respondents argued, however, that the Global Fund's assertions that the PMU had failed to communicate with the Ministry of Health adequately were not supported by their actual relationship. The way that the PMU operated in Namibia meant that PMU staff were often the ones that wrote the grant management letters to the Global Fund and the PR just signed off on them. In fact, the Country Director for the PMU was often listed as the contact person for any letter from the Ministry of Health to Geneva. As it complained about the PMU to the Ministry of Health, Global Fund Geneva was mostly communicating with the PMU.

5.4 Initial PEPFAR Financial Flows

In Namibia, most recipients of PEPFAR funding, including the Ministry of Health, were chosen at the start of PEPFAR phase 1. According to a respondent from the PEPFAR Country Coordinator's Office, other agencies that received PEPFAR funding from either USAID or CDC in Namibia were chosen through a competitive application

process. The Ministry of Health, however, received funding through a "sole-source award". As explained by a respondent from the CDC Namibia office, CDC "wanted to have a direct relationship with the government" of Namibia, so the Ministry of Health did not need to apply for PEPFAR funding. According to a respondent who previously worked for the Health Sector Response division of DSP, this is how the relationship between CDC and the Ministry of Health came about:

CDC became associated with the DSP when the DSP people moved into their new offices in 2002/03. It had been present as a small office to provide technical support to the Ministry of Health. At the time, any resources from the U.S Government were coming from USAID and the U.S Embassy in Namibia. The Ministry of Health's relationship with CDC became official when PEPFAR came into operation (Former Employee, Ministry of Health, DSP).

As defined within the Cooperative Agreements (CoAgs), between CDC Namibia and the Ministry of Health, the Ministry applied for PEPFAR funding from CDC each year, through an annual grant continuation plan. Within the plan, the Ministry of Health was required to formulate an activity plan and provide a budget for how it intended to use the PEPFAR funds within a given year. The continuation plan then needed to be approved by the CDC Headquarters in Atlanta before PEPFAR money could be disbursed to the Ministry of Health for a given budget year (Office of the U.S. Global AIDS Coordinator, 2009).

However, whereas the money for Global Fund money was held in Namibian bank accounts that were controlled by the Ministry of Health, this was not the case with PEPFAR funding. In its relationship as a sub-

recipient to CDC, the Ministry of Health could not retain large amounts of PEPFAR money over an extended period. As explained by a respondent from CDC Namibia, the CDC headquarters made a projection on the expected monthly expenditures by the Ministry of Health based on total spending approved for the year. Once the monthly budget has been allocated at headquarters, PEPFAR regulations prohibited the Ministry of Health from spending more money than had been assigned to it for a given month.

To implement activities, the Ministry of Health accessed PEPFAR funding through CDC's global online Payment Management System (PMS). An individual from the Ministry of Health was designated with access to the PMS. In early 2012, the Deputy Director for DSP had been identified as the Primary Investigator (PI) for the PEPFAR grants to the Ministry of Health. When the Ministry of Health requested money through the PMS, the disbursement request first had to be approved by CDC Namibia and CDC headquarters in Atlanta. A respondent from CDC explained that if the Ministry tried to access more than the money that had been allocated to it within a given month, then the PMS would raise an alert. The Ministry of Health then had to justify any increase in requested amount, as compared to the amount that was approved for a given month.

Another feature of the PMS was that it required the Ministry of Health to spend PEPFAR funds within 72 hours once a disbursement was

approved. As described by a respondent from CDC Namibia, the 72-hours measure was put in place to prevent PEPFAR grant recipients from earning interest on U.S Government money. Primarily due to CDC's close monitoring of the Ministry's financial activities, DSP respondents perceived themselves as having more control over Global Fund money than over PEPFAR money:

For Global Fund, once you get the money, you have it in the country. With PEPFAR it is different, the money is never in country. It remains in Atlanta, and even if after it has been approved, you request almost on a daily basis (Ministry of Health, DSP)

Respondents from the DSP perceived themselves as only marginally involved in setting the budgets and activity plans for PEPFAR funds. In reflecting on their relationship with the Ministry of Health, respondents from CDC Namibia, in contrast, described their office as existing to support the Ministry of Health to execute the terms of the CoAgs:

So there is a lot of in-kind support. There is the money that we grant directly to the Ministry to spend under the conditions of the CoAg. So as part of that, we have CoAg managers, administrators who make sure that all of the procurement rules are being followed and everything. Then we have technical advisors who work with counterparts in the Ministry to ensure that the work plan that is developed for the CoAgs and linked to the budget is executed on time and budget.... (CDC Namibia)

Some respondents from the Ministry of Health, in particular, expressed frustration with the frequent PMS requests. One respondent from RM&DC equated the process of continually having to check in with CDC

for every request, to begging for money (Ministry of Health, DSP). As a result, Ministry of Health respondents perceived CDC Namibia as running the process of planning for and management of PEPFAR funds, rather than just providing support. DSP respondents viewed these processes as being driven by the U.S Government and occurring independent of and even regardless of Ministry of Health input:

...All along the CDC technical advisors, they are the ones who have been preparing even the work plans, in terms of what should be happening and put figures on there, and then doing all this work and perhaps just getting our directors and deputy directors to agree. They submit proposals to Atlanta...(Ministry of Health, DSP)

However, when asked to reflect on whether their relationship to PEPFAR funding limited the Ministry of Health's ownership of the grant, respondents from CDC did not perceive the relationship described by DSP respondents as problematic. As described by one respondent from CDC Namibia, a lack of separation between the operations of the two agencies was appropriate because they had shared objectives:

...And sometimes we cross the line and sometimes it is appropriate for us to get in there and help get things done really...but we do have shared objectives, shared ideologies about what is going on. That grey area between advising and sometimes gets a little bit blurred. But I think a little bit of blurriness is appropriate (CDC Namibia).

Respondents from CDC Namibia articulated a relationship with the Ministry of Health in which CDC worked similarly to PMU in that their office was embedded within the operations of the Ministry. In describing their grant management functions, staff from both the PMU and CDC

recognised themselves as being critical to ensuring that the Ministry of Health met the rules and the reporting requirements of the Global Fund and PEPFAR, respectively. Staff from the PMU and CDC also sought to legitimise themselves as active partners in the Ministry of Health. Respondents from the DSP, however, only viewed themselves as active partners in the supervision of Global Fund money once it was in Namibia.

5.5 Unchanging Ownership of PEPFAR Financial Flows

At the point of decline in financial support from the Global Fund during RCC, the Ministry of Health came to the realisation that it had less control over the flow of money from the Global Fund headquarters than it had previously believed under the Round 2 grant. For PEPFAR funding, respondents from DSP perceived the Ministry of Health as having gained more knowledge of PEPFAR financial flows at the point of decline of the financing from the GHI, but not necessarily more control. According to respondents from the DSP, for the first time since the Ministry of Health started receiving PEPFAR money in 2004, CDC held a grant management workshop in early 2012, which was aimed at educating Ministry of Health staff on PEPFAR grant processes.

Respondents from DSP perceived the workshops as having been useful:

I think things are going much better with the grant. We had two sessions of training now on grant management, and with that training, we have taken much of the responsibilities that we were supposed to have all along (Ministry of Health, DSP).

Staff from CDC acknowledged that during Phase 1, DSP staff had a limited understanding of PEPFAR financial flows. Thus according to respondents from DSP, the move to give the Ministry of Health more knowledge of PEPFAR financial flows led to greater transparency on CDC budgeting activities. More financial knowledge resulted in the revelation that there was a substantial amount of PEPFAR funding that had been allocated for Namibia, but in the end was not spent. According to a respondent from RM&DC division of DSP, at the start of 2012, the Ministry of Health learned that more than 130 million Namibian dollars (approximately US\$20 million) budgeted for the 2010/2011 PEPFAR financial year had gone unspent.

In contrast to Global Fund administrators in Geneva, however, the PEPFAR officials in Namibia did not appear overly concerned that a significant amount of money allocated to the Ministry of Health ended up not being spent. As one from CDC Namibia reflected:

With any large project, you are not going to spend all the money you are given every year, and so every year we do have some residual funding leftover that gets carried over to the next year. So that is not a phenomenon that is exclusive to the Ministry of Health, every partner with rare exceptions has money left over... (CDC Namibia).

Ministry of Health officials argued, however, that PEPFAR funding was not left over just because they did not get around to using it. As described by a respondent from RM&DC, there were instances during the 2010/2011 budget year when the Ministry of Health had requested funding for activities that had already been agreed on with CDC, only to be told that the money was not available:

When people go there (to CDC) for these things that have got on their work plans, they know the money is there, but when they go there they are told, “no the rules in America have changed, x, y z is not going to be happening”. But now we have 130 million dollars, which was supposed to be spent, that was never spent (Ministry of Health, DSP).

In addition to providing more education on PEPFAR grants through workshops, respondents from CDC Namibia also indicated that they were seeking to give the Ministry of Health staff greater responsibility for managing the PEPFAR budgeting process. Despite these acknowledgements by both CDC and DSP staff on the need for the Ministry of Health to have greater control over financial flows, in early 2012, planning for and management of PEPFAR support continued to be primarily governed by U.S Government processes and structures. As confirmed by DSP respondents, the actions of the Ministry of Health remained closely monitored by CDC officials. Despite the changes in strategic focus between phase 1 and phase 2 of PEPFAR, the case study of the Ministry of Health's relationship with CDC indicates that their operational relationship remained similar during the two periods. As

perceived by respondents from the Ministry of Health, even during phase 2, PEPFAR administrators continued to govern the initiative in a way that did not encourage country ownership.

5.6 Summary

This chapter has shown that when the Ministry of Health first started to receive funding from the Global Fund and PEPFAR, it had to adopt financial flows and structures that were specifically aimed at meeting the reporting requirements of the two GHIs. However, once the financial flows structures were put in place, Ministry of Health respondents initially perceived themselves as having had a greater decision-making role in the management of Global Fund money, when compared to PEPFAR funds.

The chapter shows, however, that when compared to the financing of the Round 2 grant, funding disbursements for the Rolling Continuation Chanel (RCC) grant often arrived later than the period for which they were requested, and often in the form of fewer funds than had been requested. The Ministry of Health realised that it had less control over the flow of Global Fund money than it had previously thought. It appears that for as long as there was money readily coming from the Global Fund headquarters to Namibia, the PMU acted as a useful intermediary in the relationship between the Ministry of Health and the Geneva Secretariat.

In reflecting on the communications with the Global Fund on the delayed and reduced disbursements, some respondents in Namibia believed that rather than just admit that perhaps there was not enough funding available for the Global Fund to give to the country, the GHI sought to blame Namibia for grant mismanagement. By approving the RCC grant, the Global Fund essentially made a promise to Namibia to make the funding available to the country. The Global Fund delayed and reduced disbursements because the Ministry of Health had made provision to make up for shortfalls created by its delays. This kind of argument is very unimaginative because it does not enable the Ministry of Health to aim for better health results beyond those agreed with the Global Fund.

Whereas Ministry of Health respondents initially perceived themselves as having greater ownership of Global Fund structures and processes, and then losing that control; their perception of the autonomy that they were able to exercise for PEPFAR funding was more consistent. Respondents from CDC articulated a relationship with the Ministry of Health, in which CDC worked similar to PMU in that it was embedded within the operations of the Ministry of Health; and primarily existed to assist the Ministry of Health in its execution of the PEPFAR grant. Ministry of Health officials, however, viewed themselves as not initially having much ownership of the PEPFAR financial flows and management processes. CDC regulations prohibited the Ministry of Health from

keeping bulk amounts of PEPFAR funding for an extended period. The Ministry of Health, therefore, had to request PEPFAR disbursements soon before it needed to use the money. It then had to spend the money soon after the payments were made, or else risk needing to send back the funding that had been disbursed.

This chapter shows that the U.S Government created an opportunity for the Ministry of Health to have a better understanding of PEPFAR financial flows during phase 2. The consequences of the Ministry of Health not being entirely privy to financial information were reflected in the revelation during PEPFAR phase 2 that a lot of money had not been spent because DSP staff were not aware of it. Respondents from DSP argued that if the processes for disbursing PEPFAR funding had been more transparent, then the Ministry of Health would have known about the money that was left over.

6. Human Resources Management

6.1 Introduction

It was not only for financial flows that the Global Fund and PEPFAR initially required the Ministry of Health to set up management structures and procedures that proved to be problematic when financial support from both initiatives was on the decline. This chapter expands the human resources discussion to reflect on the overall policies that governed the recruitment and management of health workers paid by the two GHIs to implement interventions through Ministry of Health facilities. Similar to the previous chapter on financial flows, this chapter is organised around the rise and decline of funding from the two: as represented by Round 2 vs RCC for the Global Fund, and phase 1 and phase 2 for PEPFAR.

The chapter starts off by describing the procedures through which the health workers were recruited and managed when the Ministry of Health first began to receive funding from the Global Fund and PEPFAR. The chapter then examines the extent to which the Ministry of Health owned the decision-making structures and procedures for human resources management. It evaluates the implications that these practices had for Ministry of Health operations, once it faced a decline in financial support from the two initiatives.

6.2 Initial Recruitment for the Global Fund

In its regular operations, the Ministry of Health recruits using a predefined list of required skills and number of workers. Officially known as the Staff Establishment, the list defines the number of employees the Ministry of Health can hire, as well as the salary levels it can pay. It first has to be approved by the Namibian Parliament and the Public Services Commission (PSC) (MoHSS, 2010a, 2009a; Presidential Commission of Inquiry: MoHSS, 2013). The Ministry of Health's annual budget for human resources is disbursed from the Namibian Government's Treasury based on a pre-approved Staff Establishment. In using the allocated budget, Ministry of Health workers are then recruited and managed by the Human Resources Division in the Directorate of Policy, Planning and Human Resources Development (PPHRD) (MoHSS, 2008a).

The various individuals that were hired with PEPFAR and Global Fund resources were not part of the Ministry of Health's Staff Establishment. Thus they were not incorporated into the Ministry of Health's operating plan and budget as accepted by the Namibian Cabinet and disbursed from the Government Treasury (MoHSS, 2008ab; Presidential Commission of Inquiry: MoHSS, 2013). The Staff Establishment that had not taken into account the various positions and the number of health workers that were critical to enabling the Ministry to carry out the interventions that it had achieved with financial support

from Global Fund and PEPFAR (Presidential Commission of Inquiry: MoHSS, 2013).

At the start of the Ministry of Health's relationship with the Global Fund and PEPFAR, the decision was made not to recruit and not to manage health workers funded by the two initiatives through existing procedures of the Directorate of Policy, Planning and Human Resources Development (PPHRD). According to respondents from the Ministry of Health, recruiting health workers by first putting them on the Staff Establishment was perceived by both GHIs as being too lengthy a process. Thus from the start of their relationship with the Ministry of Health, the various health workers funded by Global Fund and PEPFAR were not public servants. As explained by a respondent from the Response Management Division of DSP, they belonged to a category called "in addition to the Staff Establishment".

Decisions on the working conditions of staff funded by the Global Fund were initially meant to be made through the Country Coordinating Mechanism (CCM) during the grant application process (The Global Fund, 2011a). Specific salary levels or positions indicated in the Country Coordinated Proposal (CCP) were then approved or rejected as part of the evaluation carried out by the Technical Review Panel (TRP) in Geneva on whether Namibia's grant received funding or not (The Global Fund, 2012b, 2011b). During Round 2, workers that were recruited to work for

the Ministry of Health and had their salaries paid with funding from the Global Fund were hired through the PMU.

As explained by a respondent from RM&DC, recruitment and management of staff of the Global Fund took place through a collaboration between the PMU and the Ministry of Health:

When positions with the DSP, then the DSP sits on the selection committee. If it is a PMU position, the Director of DSP knows about it, but the decision essentially lies with the PMU. The people who work for the PMU or are funded by the Global Fund follow Global Fund hiring processes (Ministry of Health, DSP).

Staff employed through the PMU for interventions that were supported by Global Fund, however, had different employment conditions from staff hired through the Staff Establishment. From the onset of the Round 2 grant, the staff employed through the PMU and the DSP to implement Global Fund grant activities were paid at higher salary levels, which were different from their Ministry of Health counterparts. According to respondents within DSP, although health workers funded by the Global Fund had higher take-home salaries, public servants also received employment-based benefits such as pension and health care, which GHI workers did not receive.

When Namibia became faced with uncertainty around when and whether the Global Fund would commit to Phase 2 of the RCC grant, the Ministry of Health became concerned that it risked losing experienced staff (Kahuure, 2011). As noted within the Ministry of Health's

communications with the Global Fund headquarters in chapter five, the delayed commitment to phase 2 of RCC funding had an adverse impact on the Ministry's ability to implement existing interventions and plan for the future (Kahuure, 2012b, 2012c).

6.3 Changing Global Fund HR Practices

As explained by respondents from the DSP, the different salary conditions between existing Ministry of Health staff and workers financed by the Global Fund were not perceived as a problem by the Global Fund when Namibia was first granted funding under Round 2. In particular, during the approval of the country's Round 2 and RCC proposals, the Global Fund had not raised any concerns about the higher salary levels at which Global Fund supported staff in Namibia would be paid. In November 2011, however, during the implementation of the RCC grant, the Global Fund Secretariat in Geneva sent an email to the Ministry of Health, mandating budget cuts for all human resources in Namibia (Bampoe, 2011). The directive applied to all recipients of Global Fund resources in Namibia. The Ministry of Health was asked to reduce the salaries of over 1,000 health workers to a range of 20 to 50 percent of first pre-approved pay (Bampoe, 2011).

As explained in the letter from the Global Fund, which mandated the salary reductions, Namibia had been asked to undertake a salary

survey of health workers paid with Global Fund resources in April 2009, before the RCC grant agreement was signed. The letter noted that due to "protracted negotiations" between the Ministry of Health and the Geneva Secretariat, the grant agreement was signed before the salary survey was conducted (Bampoe, 2011). The letter requesting the pay cuts further added that the RCC agreement had noted that "if salaries were above those justified" the Global Fund "could adjust the budget for salaries downwards" (Bampoe, 2011).

According to respondents associated with the Global Fund at both the Ministry of Health and other agencies: instead of the salary survey being carried out in 2009 at the start of the RCC grant, the study eventually took place in mid-2011. Respondents from both the Ministry of Health and the PMU argued, however, that the salary cuts were inadmissible for a variety of reasons related to how the survey was conducted. For instance, the study was not done over a long enough period to adequately capture the complexity of different salary levels in the Namibian health system. Another respondent from the PMU argued that even if the survey results were not problematic due to its methodology, the Global Fund's requests for reductions "bore no relation the findings of the study".

These same sentiments that the salary reductions bore no relation to the survey results were expressed in the Ministry of Health's response to the Global Fund's directive, which requested the salary cuts:

Upon full review of the contents of that directive, we had to conclude that it [the directive] has no logical basis and is certainly not based on the survey neither on the Round 2 Year 5 salaries (Kahuure, 2012b).

The Ministry of Health then goes on to provide three examples of the "numerous anomalies and inconsistencies, which make the directive entirely unworkable." In one example, the letter noted that Senior Data Clerks had their salaries adjusted from US\$1,556 per month to US\$1,000. The letter from the Ministry argued that this would be less than the US\$1,308 per month that the Global Fund stated could be paid to the professionally lower-ranked Data Clerks (Kahuure, 2012b).

Within the original letter requesting the salary reductions, the Global Fund had informed the Ministry of Health that it could choose to top-up the salaries that were reduced if it perceived staff as being essential to the programme (Bampoe, 16 November 2011). A former senior manager from the PMU, however, argued that in making this request, "the Global Fund Secretariat demonstrated a significant ignorance of the how its grant operated in Namibia":

What Global Fund told the Ministry is, this is what we can afford in terms of salaries; you top them up. The Ministry, of course, cannot top up salaries if the positions are not on the Staff Establishment. They cannot go to the Ministry of Finance; please give me money for this and this position because the Ministry of Finance will say: where is this position on the staff establishment? Where is the approval of the public service commission (Global Fund Namibia PMU)?

In the end, despite protestations from the Ministry of Health, the Global Fund administrators in Geneva maintained that the salary cuts needed to be made.

At the end of January 2012, Ministry of Health workers who had salaries paid with Global Fund support was informed that they would have their wages cut (Eldon-Edington, 2012). Following the salary reductions, there was anecdotal evidence from interview respondents that Ministry of Health started to lose health workers that had been financed with Global Fund money, at both the service delivery and programme management levels. Informal conversations with several individuals within the DSP who had their salaries paid for by the Global Fund also revealed that they had started to look for new jobs as they feared for the security of their employment.

The salary reductions mandated by the Global Fund impacted all organisations that were associated with the Global Fund programme in Namibia. The Namibian media's reports on the effects of the salary reductions, however, focused the reports on the implications that the pay cuts had on the PMU. According to an article in the daily newspaper, the Windhoek Observer, published on the 10th of March 2012, the salary survey found that Global Fund salaries were significantly higher when compared to 15 other public sector and development organisations working in the HIV and AIDS sectors in Namibia (Jaramito, 2012). The

salaries of the top management staff of the PMU, in particular, were reported as having been found to be "exorbitantly high" (Poolman, 2012).

According to articles in two daily Namibian newspapers, on the 15th of February 2012, the Minister sent an email to the Global Fund Chairperson Geneva, Simon Bland, asking that PMU individuals be retained at their high salaries (Jaramito, 2012; Nghidengwa, 2012). The letter apparently argued that the Global Fund programme in Namibia would collapse if the staff were not retained at their pre-established employment conditions (Poolman, 2012). According to the media reports, the Ministry of Health noted that by making the request for PMU salaries to be cut, the Global Fund had "ignored" an agreement that the Ministry of Health reached when the Global Fund Country Team visited Namibia in early November 2011 (Jaramito, 2012; Nghidengwa, 2012).

Two days after the Ministry of Health had sent the letter requesting staff to be retained at salary levels before the pay cut mandate, the Minister of Health wrote an email to the Global Fund on the 17th of February 2012, which retracted the request he had made on the 15th of February. The Minister was quoted in a daily newspaper as saying that he had to withdraw his demand after he got a phone call from Geneva and was told that the Global Fund "would not release funds to Namibia if the Ministry did not correct the situation" of the salary levels (Jaramito, 2012).

On the 28th of February 2012, the senior managers for Administration, Operations, Finance and Monitoring and Evaluation (M&E) in the PMU were informed that they would have their contracts terminated by the 31st of March 2012 (Poolman, 2012). In line with the funding committed for the first phase of the RCC grant, most PMU staff had been hired on two-year contracts, which were due to end on the 30 of June 2012. Staff had expected their contracts to be renewed for another year, once the Global Fund fully committed to funding the first three years of the RCC. Due to these salary tensions, the top PMU positions were barely functioning during the time that interview data for this thesis was collected. On the 15th of March 2012, it was clear that the Finance and M&E Managers had left their posts with the PMU. They avoided working to the end of March by applying their remaining annual leave to the rest of the month. The Operations Manager had chosen to ignore the termination letter and had declared through the media that she would be taking the Ministry of Health to the Namibian Labour Court for breach of contract (Poolman, 2012).

The Global Fund administrators in Geneva attributed the late and reduced disbursements to the Ministry of Health not adequately managing the funds. In particular, the Global Fund chastised the Ministry for paying workers salaries that were higher than deemed appropriate (Bampoe, 2011; Eldon-Edington, 2012; Masanhu, 2012).

These were, however, the same salary levels that were paid during Round

2 of the grant, and the Global Fund had not raised any objections. In the letters exchanged between the Ministry of Health and the Geneva Secretariat, the Global Fund argued that it made the decision to reduce salaries because it was concerned about the sustainability of the capacity that it created in Namibia (Eldon-Edington, 2012).

6.4 Initial Recruitment for PEPFAR

At the start of its engagement with the Ministry of Health, CDC Namibia contracted a third-party human resources consultancy company called Potentia to recruit and manage health workers paid for with PEPFAR money (Department of Health and Human Services, Office of the Inspector General, 2013). According to a U.S Government audit of Potentia's relationship with PEPFAR funds, the recruitment agency first entered into a 5-year cooperative agreement with CDC that started on the 1st of April 2006. Within the agreement, Potentia was defined as having four core functions in the Ministry of Health's relationship with CDC (Office of the Inspector General, DHHS, 2013):

1. Advertise for and recruit medical professionals, technical specialists, and administrative support personnel;
2. Manage the payroll function for PEPFAR employees;
3. And support human resources management

Through the Ministry of Health's contract with CDC, Potentia was a recipient of substantial amounts of PEPFAR funding in Namibia. In

2011, a U.S Government audit of CDC's relationship with Potentia for the budget period 1st of April 2009 through 31st March 31, 2010, found that out of a total \$39.5 million that CDC awarded to four recipients in Namibia (including the Ministry of Health), PEPFAR funds totalling \$14,486,635 went to Potentia; more than 35% of the total PEPFAR budget allocated to Namibia through CDC (Office of the Inspector General, DHHS, 2013). Within the same year of this audit, the PEPFAR Country Operational Plan for 2011 justified the use of Potentia as existing to "fill a substantial human resource capacity gap within the Ministry of Health and within broader government civil service (PEPFAR, 2011a, p. 57)."

This justification for the use of Potentia was corroborated by a respondent from CDC Namibia:

It's in 2006 that Potentia project was identified as the best practice for scaling up ART services rapidly. And so the reason that Potentia was brought on board was that there were human resources gaps. Simply put, there were too many vacancies in the field, and the government was unable to recruit and hire people fast enough to allow for the rapid scale-up of the ART services (CDC Namibia).

Through their relationship with Potentia, CDC officials perceived themselves as providing human resources consulting support to the Ministry of Health. They maintained that the Ministry of Health made all the recruitment decisions financed by PEPFAR:

The Ministry of Health to the greatest extent possible tells us what their needs are...We don't go out and say, you need this there, you

need that there. They do their own mapping; they tell us where the gaps are...We develop the position description and give it to Potentia (CDC Namibia)

Respondents from DSP, however, spoke of a relationship in which recruitment decisions were driven by CDC and Potentia:

When CDC hires people who operate for the Ministry, they hire them through Potentia. CDC communicates to Potentia that a position is sought. Potentia advertised the posts and shortlisted the candidates who are sent to CDC for an interview. People were recruited by Potentia and funded by CDC, then worked for the DSP side within the ministry (Ministry of Health, DSP).

PEPFAR representatives in Namibia considered the use of Potentia in Namibia as having been a successful strategy for the rapid scale-up of HIV and AIDS interventions in Namibia. Some respondents from DSP, were, however, sceptical. In particular, they raised concerns that the use of a third-party recruitment company had negative implications for the Ministry of Health's ability to retain the human resources capacity created with PEPFAR support:

When HIV and AIDS funding is being released, people become very innovative...they can divert some of the money to HR agencies, claiming that they will be more properly situated, instead of using government HR department. The thing is that the people coming through Potentia are not full-time staff. They are always on contract, and if the contract lapses, then they are gone (Multi-Sector Response, DSP).

These concerns around Potentia's implications for a sustainable human resources capacity in Namibia were reflected in some of the incidences that occurred when the Ministry of Health was faced with a decline in

financial support from PEPFAR.

6.5 Eventual Alignment of PEPFAR HR Practices?

The various health worker positions that were hired with PEPFAR money were defined in the Cooperative Agreements (CoAgs) between the Ministry of Health and PEPFAR. However, since the posts were not pegged to the Ministry's Staff Establishment, the employment conditions of PEPFAR-supported health workers were different from those of existing Ministry staff. During Phase 1, the doctors that were paid through the PEPFAR programme were paid higher net salaries than their Ministry of Health counterparts. In early 2011, when phase 2 of PEPFAR had been in operations for two years, the Ministry of Health made the decision to increase the salaries of all medical doctors on the government payroll. As described by respondents from the Ministry of Health, soon after the Government increased the salaries of doctors, PEPFAR administrators informed the Namibian Government that it would be phasing out funding from the country. The Government was told that the first cuts would be from the human resources budget that it had expected to receive until 2013. Namibia's total budget for personnel would be reduced by 10% each year.

As explained by a respondent from the DSP, Ministry of Health officials did not have a problem with PEPFAR choosing to reduce its total

spending in Namibia. The Ministry of Health found it problematic that when the PEPFAR administrators decided to start their reduction of funding to Namibia by first reducing the human resources budget, they did not consult the Ministry of Health or the Namibian Government. One respondent from the Multi-sector response division of DSP argued that by making the decision to reduce the HR budget without consulting the Ministry of Health, PEPFAR administrators prevented an opportunity for the Ministry of Health to define its priorities for health workers.

According to a respondent from the PEPFAR Country Coordinator's Office, the Government's salary increase was one of the reasons that decision was made to cut the human resources budget for Namibia:

One of the reasons why this piece (HR reduction) started to get triggered is that about a year and a half ago, the government increased medical officer salaries by an amount that we could not keep up. And before that we had been keeping up, keeping pace, but our finances and resources aren't getting increased any longer so we can't keep increasing the salaries (PEPFAR U.S Government employee, Namibia).

The Respondent also explained that the intention to phase out U.S Government support from Namibia came about because there was a recognition among US lawmakers and US citizens that PEPFAR funding could not go into perpetuity. These funding stakeholders needed an indicator that there was an end-point to the funding. Another respondent from CDC further argued that as gatekeepers of the money provided by

U.S taxpayers, it was up to PEPFAR administrators to make the decision on how they would carry out the decrease in financial support to Namibia. The respondent from CDC Namibia also argued that by making the decision to reduce the human resources first without consulting the Ministry of Health, they were enabling the Namibian Government to quickly figure out how to fill the inevitable gap in human resources funding that would come from a total reduction of PEPFAR money allocated to Namibia.

6.6 Ministry of Health Response to GHI Practices

Concerning human resources for Global Fund and PEPFAR supported interventions, DSP had, for the most part, worked in isolation from the other divisions of the Ministry of Health. However, when the Ministry of Health faced decreases in funding from both initiatives, the onus was placed on the Human Resources Division within the Policy, Planning and Human Resources Development Directorate (PPHRD) of the Ministry to manage the absorption of health workers. A senior manager within with the Policy Planning Division argued that this meant that the HR reductions made by the Global Fund and PEPFAR represented an organisational challenge more than a financial one.

To address the human resources implications of the expected decline in funding from the two initiatives, the Ministry of Health

established a Human Resources for Health Taskforce (HRH) in 2011. The Taskforce consisted of representatives from the Ministry of Health and donor agencies. It was tasked with overseeing the transition of human resources from being donor-funded to becoming funded by the Government by fiscal year 2014/15 (Ndaitwa, 2012; PEPFAR, 2011). Various respondents, however, pointed out that the human resources strategy only came about after PEPFAR informed the Government funding to Namibia would be reduced.

Before the Ministry of Health faced decreases in funding for personnel by PEPFAR and the Global Fund, there was an opportunity for the country to reflect on the long-term and potentially harmful implications of hiring health workers through donor-specific structures and procedures. In 2007, the Namibian Government, under the direction of Ministry of Labour, introduced a Labour Act, which prohibited the use of third-party contracting companies, such as Potentia, in Namibia (Government of the Republic of Namibia, 2007). Soon after the 2007 Labour Act was enacted, Section 128 (which prohibited the use of third-party recruitment) was challenged in the Namibian High Court by a human resources management company – similar to Potentia – called African Personnel Services (APS). APS argued that the ban on third-party recruitment agencies infringed on its right to carry on a trade, as enshrined in Article 21 of the Namibian Constitution (Horn and Kangueehi, 2009). The High Court upheld the labour ban (Jauch, 2008).

According to articles in the national media, the introduction of the 2007 Labour Act led to nearly 1,500 positions in the Ministry of Health becoming illegal because they were hired through Potentia (Maletsky, 2009). In 2012, following an appeal by APS to the Namibian Supreme Court, the Government elaborated on its original prohibition by explaining that individuals recruited through third-party companies “have the same rights as any other employee” directly hired by a contracting company (Government of the Republic of Namibia, 2012). When the amendment to the 2007 Labour Law was enacted in 2012, an article in a daily national newspaper, *The Namibian*, reported that the new rule led to a discussion between the Ministry of Health and the Ministry of Labour to address the issue of Potentia (Sasman, 2009). The Acting Permanent Secretary of the Ministry of Health at the time was quoted saying that Potentia was a "technicality" that needed to be sorted out between the Ministry of Labour and the Ministry of Health. According to the article, the Permanent Secretary would not say if the Ministry continued to hire and manage health workers through Potentia – which would be illegal according to the Government’s rules (Sasman, 2009).

Rather than using the discussions around the 2007 Labour Act to plan for the exit of the Global Fund and PEPFAR both for legal and operational reasons, the Ministry appears to have waited until it faced an actual decline in funding from the two initiatives. According to PEPFAR

documents, the U.S Government worked together with the Namibian Government to develop a human resources inventory system (PEPFAR, 2011; PEPFAR Namibia, 2012). These posts were then matched to existing vacancies within the Ministry of Health and other line Ministries. In October 2011, the Ministry of Health committed to financing all medical officers that had been previously funded through PEPFAR by early 2012 (PEPFAR Namibia, 2012). By March 2012, the HRH Taskforce had only transitioned 41 medical doctors that had been previously funded by either Global Fund or PEPFAR (Ndaitwa, 2012). According to respondents, the medical doctors were the only ones transitioned because they were deemed most critical to HIV and AIDS interventions in Namibia.

6.7 Summary

This chapter shows that before the arrival of support from the two initiatives, Ministry of Health workers was primarily hired based on a list of pre-approved positions placed on the Staff Establishment. All the posts on the list are approved by the Namibian Cabinet and the Namibian Government's Civil Service Commission. At the start of the Ministry of Health's relationship with the Global Fund and PEPFAR, however, workers associated with the two initiatives were not hired as part of the Staff Establishment that existed in the early 2000s. They were

identified by a category called in addition to Staff Establishment, which did not require approval by the Namibian Cabinet.

The creation of three different groups of workers, all working for the Ministry of Health, ended up creating challenges for the Ministry when it was faced with a decline in funding from both the Global Fund and PEPFAR. Chapter six has shown that although Global Fund and PEPFAR support increased the Ministry of Health's health worker capacity, this was done on an ad-hoc basis. The capacity was not increased as part of a long-term human resources plan. The findings described in this chapter show that the human resources practices of the Global Fund and PEPFAR for the Ministry of Health did not encourage or promote country ownership. The findings also show, however, that in the process of seeking to decrease funding to Namibia, both initiatives placed the onus on the Ministry of Health to figure out how to address the complications created by their parallel HR structures.

Even though there was a legitimate deficiency in the human resources capacity and recruitment capacity in the Ministry of Health, more effort could have been spent on initially increasing both the health worker recruitment and management capacity of the Ministry. The parallel human resources management procedures were tenable when the Ministry of Health was a recipient of substantial funding from the Global Fund and PEPFAR. In the face of declining funding from both the Global

Fund and PEPFAR, the increased human resources capacity, however, became threatened.

7. Civil Society Engagement

7.1 Introduction

In Namibia, the rise of funding from the Global Fund was perceived by national stakeholders as having facilitated the wider involvement of civil society organisations (CSOs) in deciding on and implementing HIV and AIDS interventions in the country. This chapter examines the extent to which the Ministry of Health's engagement with civil society organisations in Namibia was influenced by Global Fund grants to the country. Through mandating that proposals are submitted, and funding is managed through a Country Coordinating Mechanism (CCM), the Global Fund provided a platform for a wide-range of stakeholders to come together in planning for HIV and AIDS, TB and Malaria interventions in Namibia. As a Principal Recipient (PR) to both the Round 2 and Rolling Continuation Channel (RCC) for the HIV and AIDS grant and as the Secretariat to the PMU, the Ministry of Health's relationship to CSOs in Namibia had high potential to be influenced by Global Fund grants.

As perceived by several respondents associated with the Global Fund programme in Namibia, the initiative created funding relationships, which were not backed up by efforts to ensure that funding and interventions would be sustainable in the event of donor exit. As told by respondents in Namibia, the Namibian Network of AIDS Services

Organisations (NANASO) was one of the organisations most negatively impacted by the deteriorating relationship between the Ministry of Health and the Global Fund. As with financial flows and human resources for the Global Fund and PEPFAR in Namibia, chapter seven shows the Global Fund facilitated an increase in civil society capacity that was of a temporary nature. The CCM limited the coordination authority of the Ministry of Health.

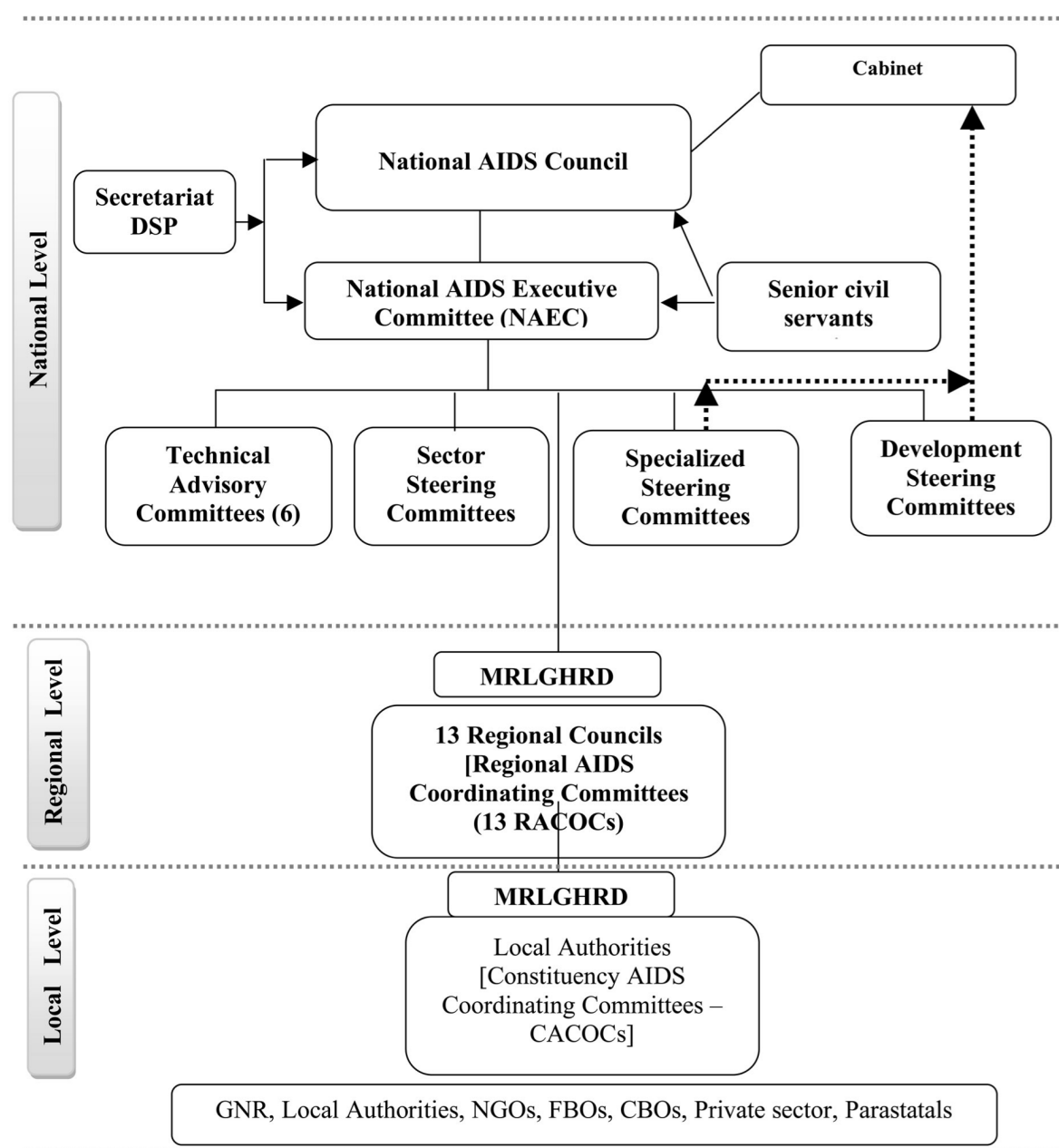
7.2 The Ministry of Health and multi-sector HIV and AIDS coordination

When Global Fund support arrived in Namibia, the Government's policy for HIV and AIDS recognised civil society engagement as crucial to effective interventions (Government of the Republic of Namibia, 2008; MoHSS: DSP, 2008). The Government, however, did not, have a particular mechanism for funding civil society organisations to engage in the implementation of HIV and AIDS services. As described in chapter four, the NSF is Namibia's main policy framework for a multi-sector response to HIV and AIDS. Through coordination structures at the national, regional, sector and community levels, the NSF positions the Ministry of Health as the agency primarily responsible for coordinating the multi-sector response to HIV and AIDS.

From its Secretariat in the Directorate of Special Programmes (DSP), the National AIDS Executive Committee (NAEC) is mandated to

provide technical leadership for HIV and AIDS interventions in Namibia for the NSF (MoHSS: DSP, 2010). NAEC is described in the NSF policy document as seeking to contribute to the national response through facilitating programme development and planning; coordination of capacity-building; partnership strengthening and management of strategic information, among other functions. NAEC membership is primarily meant to consist of people directly involved with HIV and AIDS programme planning and implementation in the country. These include the Permanent Secretaries from all 16 sector-specific Namibian Government ministries, key officials from development partner agencies, as well civil society and private sector companies and organisation (MoHSS: DSP, 2010, p. 87). With the DSP as the lead coordinator within the Ministry of Health, NAEC is identified as the key technical body for engaging with all the other HIV and AIDS coordination structures (Figure 7.1).

Figure 7-1 Coordination of the Namibian National HIV/AIDS Response, source: (MoHSS: DSP, 2010)



Chapters two and four showed that although the Global Fund's country partnerships are mainly with a limited number of agencies, which serve the role of PR, its guidelines strictly require that the application for and management of its grants should involve multiple

stakeholders from a broad range of organisations. To apply for the Global Fund Round 2 grant, the Ministry of Health, as the Principal Recipient (PR), brought together several civil society organisations to be applicants for the Country Coordinated Proposal (CCP). Within the Round 2 application for funding, the Ministry of Health was designated to focus on the biomedical components of the interventions. Civil society organisations were appointed to focus on the behavioural elements of the Global Fund-supported HIV and AIDS interventions (NaCCATuM, 2009; The Global Fund Office of the Inspector General, 2012).

In the proposal for Round 2 funding from the Global Fund, the Namibian applicants had identified NAEC to take on the role of the CCM. However, according to former Ministry of Health employee who was involved in the proposal for Round 2 funding, Namibia's plan to have NAEC take on the role of the CCM was rejected by the Global Fund. Namibia then established a CCM, which it called the Namibia Coordinating Committee for AIDS, Tuberculosis and Malaria (NaCCATuM). The general operational structure of NaCCATuM was formed to mirror the structure of the CCM as defined by the Global Fund Guidelines (NaCCATuM, 2009; The Global Fund, 2013b, 2011a).

In Namibia, the exact members of the CCM have changed over the lifetime of Global Fund operations in Namibia, but they have for the most proportionally represent the same type of organisations. As table 7.1 shows, the members of the Namibian CCM can be grouped into four main

categories: government agencies, civil society, international development institutions, and private entities (The Global Fund Office of the Inspector General, 2012).

Table 7-1 NaCCATuM Members Round 2 Grant

Type of Agency	Total in Quantity
Academic	1
Government	13
Umbrella NGO	5
PLWHV	2
People representing key populations	1
Private sector	3
Faith-based organizations	1
Multilateral and bilateral partners	5

Once Namibia established NaCCATuM, the country still envisioned it would operate in a way that aligned with existing multi-sector coordination structures such as NAEC. Within the NSF, Specialized Committees (such as the CCM) are meant to report to the NAEC, which in turn is expected to report to the Namibian Cabinet through the NAC (Figure 7.1) (MoHSS: DSP, 2010, p. 90). In line with the NSF, Global Fund stakeholders in Namibia also expected that the Ministry of Health would continue to be the lead agency in coordinating the country. Several members of NaCCATuM interviewed for this research, however, indicated that the CCM operated separately from

existing coordination structures and rarely discussed issues that were not directly related to the Global Fund. Respondents also reported that when the CCM did serve as a platform for country ownership and alignment, this was primarily limited to its role as existing to coordinate Global Fund grants.

In relation to the Ministry of Health's potential role as the potential coordinator of Namibian CCM, the Global Fund also set out specific guidelines, which made it difficult for the Ministry to chair NaCCATuM (The Global Fund, 2011). Thus respondents explained that one of the issues that defined the operations of the CCM in Namibia was an ongoing concern around conflict of interest in the function of NaCCATuM. During the early stages of the proposal for and implementation of the Round 2 grant, the Ministry of Health served as both the Secretariat and the Chair of NaCCATuM (The Global Fund Office of the Inspector General, 2012). However, according to several members of NaCCATuM, during Round 2, the Global Fund in Geneva frequently raised concerns that it was inappropriate for the Ministry of Health to be the Chair of the CCM. The Ministry of Health's role was perceived as going against the Global Fund's policy on "conflict of interest" in the running and management of CCMs (MoHSS, 2007; The Global Fund, 2013b).

The CCM is the body through which the application process for grants is meant to be coordinated, yet it is also the oversight body that is

supposed to ensure that approved grants are being implemented and managed according to the grant requirements defined by the Global Fund (The Global Fund, 2013b). In explaining the Ministry of Health's potential for conflict of interest over Global Fund grants, this is how one Government member of NaCCATuM described the Ministry's risk of conflict of interest in its role as Chair of the CCM:

We had a situation that the PR of the fund, which was the Ministry of Health, was also the one which was chairing NaCCATuM. Now you cannot be making the laws and also policing the laws yourself and the implementation, so that was also where the conflict of interest came in (Government member, NaCCATuM).

In October 2007, NaCCATuM held a workshop, which dealt with the issues of conflict of the Ministry's position as chair (MoHSS, 2007). According to the minutes from the Workshop, the majority of the members were not participating in deliberations of the scheduled meetings. There were questions around whether any of the decisions taken during NaCCATuM meetings were through consensus or were merely imposed individual decisions and whether the different constituencies were represented by their members (NACCATUM Workshop, 2007). Various NACCATUM members interviewed for this thesis indicated that representatives from the Ministry of Health and international funding agencies often drove the deliberations.

The decision was reached at the workshop that, as the PR to the Global Fund grant, the Ministry of Health could no longer legitimately

serve as the Chair of the CCM. It was agreed, however, that the Ministry of Health could remain the director of NaCCATuM until the country successfully applied for another Global Fund grant (MoHSS, 2007). In 2009, the CCM underwent a reform process, which resulted in the development of a constitution and governance policies. The CCM composition was reviewed and subcommittees re-defined. The 2009 formal constitution and governance policies provided for the role of Chair to rotate every two years amongst CCM members (The Global Fund Office of the Inspector General, 2012). As part of the reform process, the NaCCATuM Secretariat was moved from DSP to the Polytechnic of Namibia through an outsourcing agreement. As a result of the transfer, the NaCCATuM Secretariat relied on the Polytechnic's financial management systems, which already had institutional controls. The NaCCATuM chairmanship was also moved from the Ministry of Health to the National Planning Commission, which was not involved in grant implementation (Global Fund Audit, 2011). In early 2012, the National Planning Commission (NPC) was the chair of NaCCATuM (The Global Fund, 2011c).

A member of NaCCATuM interviewed for this research, however, pointed out that taking away the chairing power of the Ministry of Health was in fact pointless. The Ministry of Health was essentially still the agency with the highest authority over the Global Fund Grant in Namibia. The respondents argued that even if the Secretariat of the CCM

and the position of Chair might sound "theoretically different" from the Ministry of Health, in the end, it was still the DSP that decided on all Global Fund grant issues. As perceived by several respondents, the CCM had some power over the Global Fund grant but did not ultimately have autonomy from the Ministry of Health or have its "own powers with teeth" (Government member, NaCCATuM).

7.3 Missed Opportunity for Strengthening NAEC?

As seen by a wide variety of respondents, Global Fund grants encouraged multi-sector consultation on the HIV and AIDS response in Namibia. Many of these same individuals, however, expressed concerns that this has sometimes happened at the expense of a more comprehensive health sector and development approach:

We have thousands of working groups and technical advisory committees and task forces around HIV/AIDS. Steering committee for TB, but there is no instrument for looking into the broader health sector and then seeing whether we are not working against each other, that we collaborate to move forward (Multilateral organisation, NaCCATuM member).

As perceived by some members of NaCCATuM, the creation of this new coordination body exacerbated a general lack of coherence that already existed within the Namibian health sector between different groups all seeking to address HIV and AID.

Regarding the operations of NACCATUM, there were three major concerns that its various members expressed on its potential and shortfalls in effectiveness:

1. Many members are recipients of Global Fund resources, so they do not have the distance required to reflect on the issues genuinely
2. Members are very busy and often do not regularly attend meetings, which creates a discontinuity in discussions
3. NACCATUM is just a committee, which was mainly formed to oversee the submission of Global Fund proposals, and therefore does not have the power to enforce anything even if it relates to health system harmonisation or alignment

Various NACCATUM members also reflected on the fact that even when it does serve as a platform for country alignment, this is very limited to the proposal phase. The rest of the time members view themselves as being focused on management issues related to the Global Fund.

Although the existence of NaCCATuM was seen as problematic for confusing the coordination of Namibia's multi-sector response to HIV and AIDS, a similar structure that pre-dated it was not necessarily perceived to be more efficient.

A respondent from a multilateral organisation in Namibia, who was also an individual member of both NAEC and NaCCATuM reflected that if one was to go on NSF policy alone, NAEC could realistically be considered as being able to serve the role of the Global Fund CCM. The respondent argued that this would have done away with the need to establish NaCCATuM. The respondent from UNAIDS, however, then goes on to add that if NaCCATuM met as infrequently as NAEC did, then

the Global Fund-supported program would have collapsed. In the respondent's estimation, the CCM became "the only fully functional coordination structure that is in place to date" in Namibia. The issue of NAEC meetings not happening as frequently as they were mandated by Government policy was brought up by several of its members:

NAEC is supposed to meet at least four times per year, in two years' time, we had one meeting, which was this year...in the absence of regular NAEC meetings, overall national coordination of activities is then non-existent (Government member, NAEC and NaCCATuM).

Several respondents who were NAEC members also pointed out that when NAEC meetings did occur, high-level policy-making officials rarely attended. I observed this low attendance of the principal policy officials when I attended an NAEC meeting on the 28th of March 2012. According to the guidelines in the NSF policy, NAEC meetings are supposed to consist of a broad range of government and non-government stakeholders. Each Ministry is meant to be represented by a Permanent Secretary (PS) (who is the administrative head of each line ministry) and an HIV focal person (MoHSS: DSP, 2010).

At the NAEC meeting that I attended, only 3 out of the 15 Permanent Secretaries were present. One of these was the Permanent Secretary for the Ministry of Health, which served as both the Secretariat of NAEC and the Chair of NAEC meetings. As pointed out by one of the

organiser's of the NAEC meeting meetings only have the potential for impact if the high-level officials came:

Policy changes will occur when a high-ranking official understands why a particular action is important. Their understanding then makes it easier for the focal person to execute decisions with full agreement from the senior staff member. The person who attends is otherwise left constantly trying to justify the smallest interventions because those at the highest level within a particular ministry do not understand the HIV and AIDS within the context of larger national issues (Ministry of Health, DSP).

Several respondents also attributed the perceived ineffectiveness of NAEC to the fact that it was coordinated from the DSP in the Ministry of Health. A civil society member of both NAEC and NaCCATuM argued that coordinating the multi-sector response from the Ministry of Health perpetuated the illusion that "health should be the issue of the Ministry of Health alone". Along the same lines, a member of NAEC through the Ministry of Education attributed the lack of attendance by Permanent Secretaries from other Ministries to the fact that the PS of the Ministry of Health was the Chair of NAEC.

Concerns regarding the role of the Ministry in coordinating Namibia's HIV and AIDS response were also expressed in the country's RCC proposal (NaCCATuM, 2009). The proposal noted that the Office of the Prime Minister had an HIV and AIDS unit, and this fact could be viewed as demonstrating the Namibian Government's strong political support for addressing HIV and AIDS. The proposal noted, however,

there was not enough political will in the country for HIV and AIDS to be treated as an issue that goes beyond health (NaCCATuM, 2009, p. 4):

There is no Cabinet-level accountability mechanism for ensuring and monitoring line ministry budget allocation and implementation of sectorial activities in support of the national response to HIV and AIDS. Except for the Minister for Health and Social Services, there is limited sustained and visible high-level political leadership for the national response to HIV and AIDS and limited engagement with people living with HIV to counter high levels of stigma and discrimination.

The question around what agency should coordinate the national HIV and AIDS response in Namibia, however, solicited different opinions amongst the interview respondents. For the most part, respondents who represented international organisations such as the United Nations, PEPFAR and the Global Fund strongly argued against multi-sector coordination of the HIV and AIDS response being led by the Ministry of Health. At a donor coordination meeting aimed at addressing the transition of Global Fund and PEPFAR, which I attended, one participant from an international development agency operating in Namibia argued that multi-sector coordination of HIV and AIDS in Namibia might be better placed with another national authority, which was not the Ministry of Health. The individual who raised this issue argued that coordination by a separate agency, rather than the one mandated to address health, had been shown to work well in other countries.

The Director of the DSP who was in attendance at the donor coordination meeting responded to this statement by saying, "Namibia is

not other countries. It [The Ministry of Health] has been given the mandate by the Namibian Government to spearhead the entire national response to HIV and AIDS, and that is where it will remain". In speaking about the role that the Ministry of Health has played in the response during Global Fund support, a respondent from the HIV and AIDS Health Sector Response division of DSP, however, admitted that the Ministry of Health had not done a good job of coordinating other stakeholders. As explained by respondents from the Resource Mobilisation and Donor Coordination (RM&DC) of DSP, it was the Ministry of Health, which sought out the various CSOs that were eventually applicants to the Round 2 and RCC grants, as well as those that eventually became members of NaCCATuM.

7.4 NANASO: Questions of CSO Sustainability?

NANASO was established in September 1991, following the independence of Namibia in 1990. A senior manager at NANASO, who was interviewed for this study, explained its establishment in the following way. Between 1986 and when the country gained independence in 1990, a variety of civil society organisations and various stakeholders, including the Namibian Government, had been working on addressing HIV and AIDS independently. After Namibia's independence, some of these stakeholders decided that there was a need to develop a civil society

grouping, which would be “a common platform, common body, which can represent, advocate, facilitate and coordinate” on behalf of the civil society actors. Hence, NANASO was established.

NANASO’s relationship with the Global Fund started in 2005 when the organisation was first added as a sub-recipient (SR) for Round 2 funding under the Ministry of Health as the PR (NaCCATuM, 2009). As described in chapter three, NANASO was then added as a second PR to Namibia’s successful application for Round 2 RCC funding. According to several respondents involved in the RCC proposal, the process was different from the Round 2 funding application in two main ways. First, Namibia treated it like a continuation of Round 2 activities. Second, the RCC application did not "include wide-ranging consultations" between HIV and AIDS stakeholders in Namibia, as was the case in the proposal for Round 2 funding. The RCC work plan identified civil society organisations as being critical to the HIV and AIDS response particularly for community-based health care and People Living with HIV (PLHIV) and identified NANASO as PR to meet this goal (NaCCATuM, 2009, p. 12).

As described by various respondents, however, NANASO’s relationship with Global Fund money under the RCC was not a smooth one. First of all, although the RCC grant was supposed to start in January 2010, NANASO did not receive its first disbursement until November 2010 (The Global Fund Office of the Inspector General, 2012).

The delays in payments to NANASO were due in part to the protracted grant negotiations, which also caused late disbursements to the Ministry of Health, as discussed in Chapter Five of this thesis. As part of its inclusion as a Global Fund PR, the staffing structure of NANASO was amended to include 11 new positions associated with administering the RCC grant (NaCCATuM, 2009). As explained within the RCC application, the justification for changing NANASO's staffing structure was to enable it to be better equipped to manage the Global Fund grant.

According to the NANASO website, in 2013, the primary function of the organisation was to serve as an umbrella body for NGOs, CBOs and other agencies involved in providing HIV/AIDS services in Namibia, through four main activities (NANASO 2013):

1. Network and coordinate HIV/AIDS activities
2. Build capacity and facilitate capacity building within civil society
3. Communicate with various members on any issues and policies related to HIV/AIDS
4. Advocate on behalf of its members and be their voice on issues to which they want to call attention

By including NANASO as a PR in the RCC proposal for HIV and AIDS, the Namibian applicants sought to expand the organisation's activities so that it could also be involved in managing the implementation of HIV and AIDS interventions (NaCCATuM, 2009). Within the RCC proposal, NANASO was described as seeing its "grant management role as complementary to its network support role." The proposal further added that "NANASO's real strength lies in its

convening capacity, being able to bring disparate and often competing organisations together to discuss issues and to assist in putting groups in touch with each other through its extensive network of affiliates" (NaCCATuM, 2009, p. 4.9.1).

The Audit of Namibia's RCC grant in 2011, however, reflected concerns that NANASO became too dependent on Global Fund resources, at the potential detriment of the sustainability of the organisation and its interventions (The Global Fund Office of the Inspector General, 2012). During RCC, 90% of NANASO's operational funds came from the Global Fund, while several other organisations had more than 50% of their operations financed by the grant:

Dependency on a single funding source places significant pressure and risk on Global Fund resources and brings into question the sustainability of these organisations and the activities they implement (The Global Fund Office of the Inspector General, 2012, p. 18).

Respondents from NANASO recognised that the agency's relationship with the Global Fund had put it in a position where it had to reduce some of its networking and training activities:

When NANASO was a sub-recipient for example, we were doing all our programs, advocacy, networking, even from the Global Fund budget. What Global Fund did was that some of these items were cut, when we became a PR... We are supposed to increase rather than decrease. For example, we can only cater for maybe five training, compared to 20 or 30 pieces of training, which are needed. Some of the 13 regions are not getting appropriate civil society training to reflect their local conditions and needs (Global Fund Namibia PR, NANASO)

The Global Fund Audit on the Namibia RCC grant in 2011 also found NANASO to have mismanaged money. NANASO was found to be unable to account for almost US\$300,000 of its RCC grant (The Global Fund Office of the Inspector General, 2012). Regarding its role as local guarantor of the activities of other CSOs, the audit found NANASO to have weak governance and oversight structures. The audit report noted that these inefficient structures resulted in expenditures that were not adequately supported; expenditures made outside the approved work plan; and incomplete financial records. The Audit report also recommended that NANASO should pay back the money for which the it could not account (The Global Fund Office of the Inspector General, 2012, p. 14).

As a result of the programme-wide salary reductions discussed in Chapter six, all of NANASO's sub-recipients ended up owing money to the Global Fund. In the early months of 2012, there was a lot of uncertainty around whether CSOs in Namibia had to pay back money to the Global Fund or not. As explained by several respondents from the organisations that were impacted by salary deductions, NANASO had informed recipients in January 2012 that the Global Fund had mandated that they all make cuts to the salaries funded under the RCC grant. Once the CSOs had implemented the cuts, they were then informed by NANASO that it had made a mistake in asking them to reduce the salaries as from January 2012:

We immediately implemented the 49, 48, 50 percent pay cuts. Our staff just continued to work until we learned three weeks ago that apparently the salary cut was not meant to be affected immediately...Well, we understood that pay cuts were with immediate effect. But then it was again changed that it was not supposed to be implemented quickly (Global Fund CSO recipient, NAEC and NaCCATuM member).

In reflecting on the expectation that sub-recipients would be required to pay back the Global Fund, a respondent from one of NANASO's sub-recipients rhetorically and incredulously asked: "Were we supposed to have been prescient and expected there to be a 50% cut and therefore only pay 50% of what we have?" According to a respondent from NANASO who was involved in the overall administration of the grants, if the Global Fund did require CSOs in Namibia to pay back the money paid for salaries, very few of them would be able to pay back the money owed. If they did somehow manage to pay the money back, they would then not survive to carry out their functions as they did before the RCC grant. Due to the money that CSOs owed or potentially owed, there were concerns among Global Fund stakeholders in Namibia that even though the Global Fund's support had facilitated an increase in access to services, it also potentially undermined future CSO efforts to address HIV and AIDS.

A representative of the PEPFAR initiative in Namibia, however, argued that it was not necessarily the donors who were to blame for the situation in which the Namibian CSOs found themselves. The respondent argued that the substantial amount of money that was made available

from the Global Fund to organisations in Namibia made them complacent. Also reflecting on the same issue around the perverse incentives created by GHI funding, a respondent from the PMU, criticised the Global Fund for making money available, but not carrying adequate due diligence to ensure that the CSO recipients could sustain efforts.

Respondents from DSP indicated that the Ministry of Health primarily included CSOs in the application and implementation of the Global Fund grants because that was what was required for the country to submit a successful grant. As described by the individuals within the DSP, there is a strict requirement that they keep detailed lists of all the stakeholders that have participated in the consultation process. As explained by a respondent from DSP, the broad stakeholder engagement of the various actors often functioned more like a "box-ticking" exercise. The decision to add NANASO as a PR was made at a NaCCATuM meeting held on the 1st of February 2007. The minutes from the meeting noted that the Global Fund had a new policy that a country submitting a CCP with only one PR would be disqualified (NaCCATuM, 2007). NANASO was therefore added as a second PR to Namibia's proposals, following a requirement by the Global Fund.

As perceived by several respondents from CSOs that addressed HIV and AIDS in Namibia, the potential negative impacts of a decline in the Global Fund money were exacerbated by the fact that their organisations did not have access to alternative sources of national

funding. Since the Government had more reliable access to finance, the various Global Fund CSO recipients were looking to it to fill the funding gaps that would be left by the phase-out of Global Fund resources. A respondent from the DSP perceived the challenge created by the potential exit of donor funding as an opportunity for the Namibian Government to more strategically engage with CSOs:

HIV and AIDS are just becoming a chronic disease like any other. It, therefore, needs to be addressed in a manner that goes beyond treatment and looks at things like the fact that people on treatment require things like food and water...So, I am hoping that at least we can sell the idea that we should improve funding civil society, which is the backbone of the health response... they are the link between the health sector person and the community (Ministry of Health, DSP).

However, when it was approached for support, the Ministry of Health informed CSOs that it had no intentions to fund them directly. As perceived by CSO respondents in Namibia, the Ministry of Health had fallen short of its mandate as the primary coordinator of the country's multi-sector response to HIV and AIDS. Even though the Namibian Government has committed – through the NSF – to assisting other stakeholders to mobilise sustainable funding resources, it did not step in to financially support CSOs that were threatened with a decline in Global Fund support.

Respondents from the Ministry of Health argued that it would not fund CSO because the Namibian Government did not have an existing budget mechanism of financing them. These sentiments were expressed

by the Permanent Secretary (PS) of the Ministry of Health at the NAEC meeting on the 28th of March 2012. As explained by the PS, the Ministry would continue to ask civil society organisations to engage in both health sector and multi-sector planning and implementation, "but there are currently no plans in place for the Ministry to provide money to civil society". When asked to respond to the Ministry of Health's position that there is no budget mechanism to fund CSOs, a respondent from NANASO criticised the Namibian Government for failing to learn from other countries:

The Government has been telling civil society that there is no mechanism to fund civil society... The same government is living in the same global village where other governments are funding civil society. What is so difficult for them to go and learn what others are doing? (Global Fund Namibia PR, NANASO)

Another respondent from a CSO that was not a recipient of Global Fund money, however, argued that the decrease in donor support and its potentially undermining health system impacts were not necessarily a bad thing for Namibia. The respondent argued that the transition from donor support could be viewed as either "an opportunity for country ownership or a crisis of health".

7.5 Summary

This chapter shows that when Namibia first applied for Global Fund support, the country was required to establish a CCM, which it

called NaCCATuM. By requiring the establishment of a Namibian CCM and requiring it to operate in a specific way, the Global Fund appears to have ended up constraining the Ministry of Health's role as the lead coordinator of Namibia's multi-sector response to HIV and AIDS. By requiring the establishment of a Namibian CCM, Global Fund support led to the duplication of existing Namibian multi-sector coordination structures. In contrast to NAEC meetings, respondents believed that Global Fund CCM (NaCCATuM) meetings occurred when they were supposed to and were attended by individuals with the ability to directly influence the implementation of the Global Fund programmes in Namibia. The establishment and operations of the CCM appear to have allowed for a temporary indication of country ownership.

Several respondents attributed the ineffectiveness of NAEC to the role of the Ministry of Health as the Secretariat and Chair of proceedings. They argued that by having the Ministry of Health as the lead agency in the multi-sector response, HIV and AIDS became exclusively viewed as a health issue that did not motivate buy-in from other sectors. When Namibia faced a decline in financial support from the Global Fund, the same respondents who criticised the position of multi-sector coordination being with the Ministry were also the ones who expected the Namibian Government to step in and meet the financial gap that would be left.

This chapter has also shown that the Global Fund created a demand for CSO funding in Namibia, which did not sufficiently take

sustainability into account. The Global Fund appears to have created a situation in which CSOs became engaged in providing HIV and AIDS services because the money was available, even though they did not necessarily possess the financial capacity to sustain interventions beyond donor support. The potential decline in Global Fund support not only threatened the interventions it had funded, but also the activities that Namibian CSOs had implemented before they became grant recipients.

The case study of NANASO was presented to illustrate the dilemma, which Global Fund support created for CSO organisations in Namibia. NANASO was supposedly added as a PR under the RCC to facilitate greater impact of CSO in the country's response to HIV and AIDS. Interview and document data indicate that in becoming a PR, NANASO became too dependent on the Global Fund financial support. When Global Fund financial assistance to Namibia was threatened, the existence of NANASO also became threatened. Rather than building on its existing strengths, NANASO's relationship with the Global Fund money appears to have undermined the organisation.

As expressed by several respondents representing CSO recipients of Global Fund money in Namibia, the failure for the country to make provisions for the decline in donor support would potentially undermine the progress that had been achieved in the non-biomedical components of HIV and AIDS interventions. As long as there was Global Fund money in Namibia, the Ministry of Health and other stakeholders appear to have

held onto a fragile partnership. The Namibian Government has never had a budget mechanism that allows it to fund non-government organisations in the health sector. Thus even though civil society organisations have been critical to the success of the HIV and AIDS intervention, the relationship as defined under the Global Fund terms did not take sustainability considerations into account.

8. Discussion

8.1 Introduction

Global health initiatives (GHIs) such as the Global Fund and PEPFAR have been criticised for distorting country ownership by planning and defining the strategies by which they seek to address the health issues. They have faced criticisms for duplicating health systems management and monitoring structures and procedures in recipient countries (Balabanova et al., 2010; Biesma et al., 2009; Druce and Dickinson, 2008b; Riddell, 2007; Walker, 2009). These country level practices of the Global Fund and PEPFAR have been criticised for being contradictory to the objectives of ownership and long-term health systems strengthening (Atun and Kazatchkine, 2009; Cailhol et al., 2013; Collins and Beyrer, 2013; Marten, 2015; Oomman et al., 2008). Global Fund and PEPFAR practices potentially undermine the ability of recipient country to sustain the health systems gains that they might achieve (Craveiro and Dussault, 2016b; Hanefeld and Musheke, 2009; Marten, 2015; Oomman et al., 2008; WHO Maximizing Positive Synergies Collaborative Group, 2009).

Namibia was initially primarily eligible for funding from the Global Fund and PEPFAR due to the country's high HIV and AIDS prevalence. And it was considered a prime candidate for the financing from both GHIs when their focus was on funding countries to rapidly

scale-up their HIV and AIDS interventions. When it first started receiving financial support from both initiatives, the Namibia government was already providing free access to HIV and AIDS services and had a long-standing policy framework for addressing HIV and AIDS. With primary reference to the country's Ministry of Health, the thesis examined Namibia's relationship with the Global Fund and PEPFAR.

Interview data for this thesis was collected between February 2012 and June 2012 through a research placement with the Ministry of Health. During this time, a wide range of respondents indicated that financial support from the Global Fund and PEPFAR to Namibia was on the decline. With the transition as a cross-cutting theme throughout, a key focus of the thesis was to understand the ways in which the structures and procedures, which governed the Ministry of Health's relationship with the Global Fund and PEPFAR encouraged country ownership at both the rise and decline of GHI funding to the country.

The results presented in chapters five, six and seven indicate that when the Global Fund and PEPFAR first started increasing funding to Namibia, both initiatives required the Ministry of Health to set up structures and procedures that primarily focused on meeting the rapid-scale up priorities of the two initiatives. As described in chapter four, the Namibian Government policy has designated the Directorate of Special Programs (DSP) the responsibility to manage external financial flows for HIV and AIDS to the public sector (MoHSS, 2009, 2008c). The arrival of

Global Fund and PEPFAR funding was, however, associated with an establishment of administrative structures specifically aimed at the two initiatives. Chapter five shows that the Global Fund required the creation of a Programme Management Unit (PMU) in the Ministry of Health. While PEPFAR funding was channelled and managed through the structures of CDC Namibia (Office of the Inspector General, USAID, 2011; The Global Fund, 2004; The Global Fund Office of the Inspector General, 2012). This thesis uses DSP's relationship with the PMU and CDC Namibia as a case study of the interactions of the Global Fund and PEPFAR and the Namibian health system and how they promote or undermine country ownership and institutional autonomy.

This thesis contributes to the global health policy debates on how to best use support from GHI to address HIV and AIDS at the level of one country. It is concerned with evaluating the ability for countries to steer their HIV and AIDS program at the national level in their engagement with GHIs. This thesis seeks to contribute to emerging literature that aims to examine what might happen once GHIs depart (Amaya et al., 2014; Dodd and Lane, 2010; Merson et al., 2012; Mills et al., 2010). Given the findings presented in the last three preceding chapters, this chapter draws together the various inter-related elements that this thesis has examined. These are HIV and AIDS global health initiatives; Namibian health system; country ownership; institutional autonomy; health

systems strengthening; financial flows; human resources management; government and civil society engagement.

The results chapters show that the influences of Global Fund and PEPFAR on Ministry of Health ownership at the rise and fall of funding to Namibia reflect their institutional arrangements at the global level. In Namibia, parallel administrative structures appear to have been tenable as long as there was a continuous stream of money from the Global Fund and PEPFAR to prop them up. Thus, it is not necessarily the parallel structures themselves that are problematic (Amaya et al., 2014; Balabanova et al., 2010; Cohen, 2006; Druce and Dickinson, 2008b; Rasschaert et al., 2011). The findings presented in chapters five, six and seven indicate that parallel structures became problematic when the money used to establish and initially operate them began to diminish.

The approach in this thesis, however, has its limitations in providing a comprehensive picture on the influence of external funding in Namibia. The relationship between international actors and recipients is also known to be subject to power dynamics (Buse and Harmer, 2004; Easterly, 2008; Riddell, 2007). The lack of power analysis is one of the limitations of this thesis. This lack of power analysis and other limitations to this thesis will be discussed in the last section of this chapter.

8.2 Country Ownership and Autonomy in Namibia

At the national and the international level, the Namibian Government has committed itself to being the steward of the HIV and AIDS response in Namibia (Government of the Republic of Namibia, 2008, 2004b; MoHSS, 2005). As presented in chapter four, three different Medium Term Plans for HIV/AIDS (MTPs) and the National strategic framework for HIV and AIDS response in Namibia, 2010/11-2015/16 (NSF) defined the Government's strategy for HIV and AIDS (MoHSS: DSP, 2010, 2008b). In addition to setting the Namibian Government's policy for the country's HIV and AIDS response, the MTPs and the National Strategic Framework for HIV and AIDS (NSF) also define the implementation structures and multi-sector coordination framework of the country's response. The MTPs and the NSF both designate the Ministry of Health the stewardship role of overseeing both the health sector and multi-sector response efforts to address HIV and AIDS (Government of the Republic of Namibia, 2004; MoHSS: DSP, 2010, 2008b). The Namibian Government was already providing a limited amount of free access to HIV and AIDS treatments before it began to receive financial support from the Global Fund and PEPFAR (MoHSS et al., 2010).

This thesis has shown that the Ministry of Health changed its existing operations to accommodate Global Fund and PEPFAR funding. The extent of adaptation is reflected in the events that occurred when the

country faced a decrease in the financing from the two initiatives. At the same time as the Ministry of Health incurred a decrease in financial support to address HIV and AIDS, it also experienced a shift in operations. The findings in this thesis show that the level of recipient ownership can vary depending on whether external funders are seeking to increase or decrease financial resources. The initial administrative procedures for financial flows, human resources recruitment and civil society engagement, were not only aimed at meeting the health sector objectives as defined by the two initiatives. They were established and initially operated independently of existing Ministry of Health procedures. Issues around country ownership and their implications for health systems strengthening and sustainability of increased health systems capacity appear only to be seriously addressed by the two initiatives, and the Namibian Government as the two GHIs sought to demobilize financial support to Namibia.

8.2.1 Financial Flows

The Global Fund initially positioned itself as allowing countries to define the financial management structures of the programs that it funds (The Global Fund, 2001a). However, as chapter two showed, recipients of Global Fund grants, where often initially required to manage grants and financial flows according to structures and processes that have been defined by the GHI (Atun and Kazatchkine, 2009; Biesma et al., 2012;

Marten, 2015; WHO Maximizing Positive Synergies Collaborative Group, 2009; Windisch et al., 2011). When Namibia was first approved for the Round 2 grant, it was required to establish specific grant management positions for the Global Fund grant, before the country received its first disbursement. The Global Fund requested the Ministry of Health to create the positions that eventually formed the PMU, even though the Namibian proposal had identified the DSP as the unit that would carry out grant management functions. In making the demand on the Ministry of Health to establish the PMU, the Global Fund deviated from its principles of encouraging country ownership. The Namibian PMU operated as a semi-autonomous entity within the Ministry of Health (Atun et al., 2009).

As the PR to the Global Fund grant in Namibia, it was the Ministry of Health's responsibility to request disbursements from the Global Fund and then allocate them appropriately to the sub-recipients in the country. In conjunction with the PMU, the Ministry of Health approved, received and disbursed all Global Fund money to sub-recipients. Based on their relationship with the PMU and the process for requesting disbursements during Round 2 of the HIV and AIDS grant, Ministry of Health respondents perceived themselves as having ownership over the management and disbursement of funds.

The organisational autonomy of the Ministry of Health was, however, somewhat influenced by the presence the PMU, which acted as

an administrative intermediary to the Global Fund. Respondents described a situation during Round 2 of the Global Fund grant in which when the Ministry of Health requested disbursements on its grant, they were quickly approved for the amounts required. In contrast, during the Round 2 RCC grant, the Ministry of Health experienced extensive delays on disbursements from the Global Fund in Geneva. When the Global Fund disbursed funds, the Ministry also received fewer amounts than it had requested (Bampoe, 2011; Eldon-Edington, 2012; Kahuure, 2012c).

The Global Fund administrators in Geneva attributed the late and reduced disbursements to the Ministry of Health not adequately managing the funds. In particular, the Global Fund chastised the Ministry for paying workers salaries that were higher than deemed appropriate (Bampoe, 2011; Eldon-Edington, 2012; Masanhu, 2012). The role that the PMU played as an intermediary between the Global Fund Geneva office and the Ministry of Health became constrained when there was a decrease in grant funding that was coming to Namibia. Chapter Six shows that as a result of the Global Fund requiring Namibia to reduce salaries during year 2 of the RCC grant, the Ministry of Health had to prematurely terminate the contracts of senior management staff in the PMU. At the same time that the Ministry of Health had to terminate the contracts of senior PMU staff, it was also dealing with the challenges of getting the required disbursements from the Global Fund. In the absence

of a properly functioning PMU, the responsibility then lay with existing Ministry of Health staff to manage the relationship with the Global Fund.

The issues related to late and reduced disbursement in Namibia appears related to decreased international funding and the Global Fund's failure to acknowledge early on that there was a problem. At the global level, the Global Fund did not have as much money as it appears to have initially anticipated (Kapilashrami and Hanefeld, 2014; Kirigia et al., 2011; Leach-Kemon et al., 2011; Lewis and Verhoeven, 2010). Even after there were indicators that it would not necessarily be able to meet its existing funding obligations, the Global Fund continued to make calls for funding (Health Gap, 2011; The Global Fund to Fight HIV/AIDS, TB and Malaria, 2008).

In comparison to the Global Fund, PEPFAR was not established with any intentions to promote country ownership in the flow and management of the initiative's finances. Through the establishment of Office of the Global AIDS Coordinator (OGAC), and through the annual Country Operational Plan (COP) process, PEPFAR was established to ensure that U.S Government agencies were setting HIV and AIDS priorities in a coordinated manner. The argument was made that this inevitably allows for a reduction in duplicated efforts and a decrease in the potential wastage of U.S taxpayer money (Fan et al., 2013; Navario, 2009). As perceived by Ministry of Health respondents, PEPFAR administrators did not necessarily apply this larger collaborative

approach in the way that they engaged with the Ministry in the flow of finances.

Chapter Five indicates that in their initial relationship to PEPFAR, respondents from DSP perceived themselves as having limited ownership over money granted to Ministry of Health. According to DSP respondents, the requests for disbursements on the PEPFAR grant were processed and closely monitored by CDC staff. Respondents from CDC Namibia sought to characterise the agency as a non-implementer that only supported the Ministry of Health. Respondents from the Ministry of Health, however, perceived themselves as supporting the activities of CDC Namibia, rather than the other way around. Right from the process of applying for PEPFAR funds, to requesting disbursements on grants, making decisions on grant implementation, and monitoring the responses, Ministry of Health respondents perceived themselves as engaging by U.S Government rules as overseen by CDC Namibia.

Ministry of Health respondents expressed a relationship that implied that the Ministry was viewed as a useful conduit for the U.S Government to achieve its PEPFAR objectives with little regard for the Namibian Government's existing operational structures for HIV and AIDS management. Respondents from CDC Namibia did not refute this perception of limited Ministry of Health autonomy. In fact, representatives of PEPFAR readily admitted that they were entitled to

make decisions on behalf of the Ministry of Health given their roles as local gatekeepers of PEPFAR funding.

In relation to money from the Global Fund, the relationship between the Ministry of Health and the PMU was uniquely Namibian. The relationship between CDC and the Ministry of Health was a direct reflection of PEPFAR operations at the global level (Fan et al., 2013; United States Department of State and the Broadcasting Board of Governors Office of Inspector General, 2010b). Inherently, PEPFAR was a bilateral initiative. It existed to fulfil the foreign relations goals of the U.S government (Merson et al., 2012; Office of the U.S. Global AIDS Coordinator (OGAC), 2004; Riddell, 2007). As explained by CDC respondents, it was the U.S Government's money, so they had to manage it according to U.S Government requirements.

As described in Chapter One, PEPFAR Phase 1 (2004-2008) did not have country ownership and health systems strengthening as one of its clear overriding objectives. The strategy documents for the second PEPFAR phase 2 (2009-2013) on the other hand sold the initiative as having a "focus on transitioning from an emergency response to promoting sustainable country programs." Unlike the first phase of PEPFAR, which specifically sought to expand the access to these services mainly, PEPFAR phase two spoke directly to issues of health system strengthening (110th USA Congress, 2008). Representatives of the PEPFAR program in Namibia were eager to create a distinction between

the two phases of funding. They constructed PEPFAR phase one as being about scale-up, while PEPFAR phase two was about sustainability and country ownership. Similar to the differences between Round 2 and RCC, the two different PEPFAR phases presented an analytical focus for the thesis on the rise and fall of GHI funding in the country.

Given its new emphasis, one would expect PEPFAR 2 to have operationally shifted from its US-centric approach towards greater country ownership (Fan et al., 2013; Navario, 2009; United States Department of State and the Broadcasting Board of Governors Office of Inspector General, 2010b). As the example of Namibia detailed in this thesis shows, there was no fundamental change in the structures and relationships that governed the operations of PEPFAR funds at both the global and national level. Similar to PEPFAR 1, the application process, financial management, and operations for human resources for PEPFAR 2 remained primarily driven by the US Government and its representatives.

During PEPFAR phase 2, the decision to reduce funds to Namibia was made with limited input from the Ministry of Health and the Namibian Government (110th USA Congress, 2008; Holmes et al., 2012). Staff in the Ministry of Health, specifically in DSP, also had to take on greater financial management responsibilities once the PEPFAR administrators in the USA made the decision to decrease the amount of financial support provided to Namibia. Once staff in the DSP were given

greater responsibilities for managing PEPFAR money, they found out that there had been a significant amount of unspent grant money during phase 1. Due to the initially CDC-driven and opaque financial flow and management structures of PEPFAR funding, the Ministry of Health had not been aware that the money was available.

For financial flows, respondents from the Ministry of Health expressed concerns that even though Namibia was granted funding from both the Global Fund and PEPFAR, the money never belonged to it. Through setting up the relation with the PMU (for Global Fund) and CDC Namibia (for PEPFAR) as a way to manage their money and closely monitor the operations of their grants, the two GHIs undermined the Ministry of Health's autonomy. Some respondents from the Ministry of Health went as far as to say that they were constantly made to feel that the GHIs did not trust the Ministry with their money. There was the impression among respondents from the Ministry of Health that even if CDC Namibia and the Global Fund PMU were very efficient at managing and monitoring their individual grants, this resulted in a temporary form of effectiveness in the Ministry. Respondents argued that for a sustainable Ministry of Health capacity, GHI funding could have been used to more efficiently address the existing grant management capabilities deficits in the Ministry of Health.

Inadequate human resources capacity was a limitation to Namibia's capacity to rapidly scale-up HIV and AIDS interventions when financial support from the Global Fund and PEPFAR first arrived in the country. However, as in other contexts, human resources deficits in Namibia were addressed with Global Fund and PEPFAR financial support, but not as part of a long-term strategy for the country (Biesma et al., 2009c; Cailhol et al., 2013; Drager et al., 2006; Schneider et al., 2006; Vujicic et al., 2012). The recruitment procedures and the salary levels associated with funding from the Global Fund and PEPFAR were issues that respondents from the Ministry of Health kept on bringing up. The salience of these matters was apparent because the adverse implications of a lack of alignment between Global Fund and PEPFAR health worker management and salary levels revealed themselves during the collection of interview data for the thesis.

Chapter Six shows that health professionals paid for with PEPFAR funding to work for the Ministry of Health were initially hired and managed through a recruitment agency called Potentia. The salary levels paid to PEPFAR staff were also different from the wages of their existing Ministry of Health counterparts. In findings reflective of both Global Fund and PEPFAR operations in Namibia, a 2011 U.S. Government audit of PEPFAR funds in the country found two critical elements missing concerning human resources (Office of the Inspector General, USAID,

2011). The first was a lack of transition plan for shifting the cost of workers' salaries to Namibian entities. The second was the lack of baseline data, indicators, and targets for human resources for health activities. The Audit predicted that the identified health systems building weaknesses would potentially hinder Namibia's ability to sustain its HIV efforts and gains in the event of total withdrawal of PEPFAR funding. The U.S Government Audit specifically criticised PEPFAR funding for being "narrowly targeted at addressing HIV/AIDS without knowing whether those HRH (human resources for health) salaries fit within the current government structure or civil society (Office of the Inspector General, USAID, 2011, p. 5)".

Although the Global Fund and PEPFAR contributed to improved HIV and AIDS outcomes in Namibia, the various health worker positions and operational structures were not integrated into larger Ministry of Health operations (Presidential Commission of Inquiry: MoHSS, 2013, p. 79). In seeking to make the health worker transition, PEPFAR officials in Namibia, placed the onus on the Ministry of Health to manage the issue of Potentia. Any attempts by the Ministry of Health to quickly transition staff from being funded by PEPFAR to having them financed by the Namibian Government were, however, complicated by the initial use of Potentia. Rather than seeing it as problematic, PEPFAR officials in Namibia characterised Potentia as a having been a successful "proof of concept" for addressing human resources limitations at the scale-up HIV

and AIDS interventions. This perception of the success of Potentia is also reflected in PEPFAR documents at the global level.

In 2006, the U.S Government's Department of Health (DoH) produced a report for its PEPFAR implementing partners agencies, which presented CDC Namibia's relationship with Potentia as a best-practice for rapidly scaling up ART service delivery (USAID and TeamSTAR, 2006). According to the report from DoH, the use of third-party agencies such as Potentia meant that PEPFAR efforts to put people on treatment would not be encumbered by the weak human resources recruitment and management capacities of grant recipients (USAID and TeamSTAR, 2006). This kind of argument represents a very myopic view of donor support for HIV and AIDS interventions. By using Potentia as a best-practice example, the DoH was essentially sending the message that the focus of PEPFAR funding should be aimed at scaling up interventions as quickly as possible; rather than viewing grant recipients such as the Ministry of Health as key partners who might have difficulties that need to be addressed in the long-term.

Namibia's application for an RCC grant as a continuation of the Round 2 HIV and AIDS grant from the Global Fund requested a human resources budget that would increase every year for the first three years of the grant. The country's proposal then proposed a reduction of the Global Fund's contribution for some health workforce positions by 10% per year between years 3 and 6 of the RCC grant. The proposal stated

that the Namibian Government would cover the reduction in the human resources budget during the second half of the RCC grant (NaCCATuM, 2009). Despite claims in the RCC grant application for the Namibian Government to be able to sustain health worker funding that had first been provided by Global Fund, the Ministry of Health appears to have been caught by surprise when both GHIs sought to decrease their human resources budget.

Sustainable human resources for health strengthening is a complex process, depending mostly on country-specific health worker production and retention factors. GHIs could assist in these strategies, provided that they are flexible enough to incorporate country-specific needs regarding funding (Cailhol et al., 2013). Cailhol et al. (2013) examined the processes and content of human resources for health policy shifts in 5 countries associated with the Global Fund and PEPFAR: Angola, Burundi, Lesotho, Mozambique and South Africa. In all countries, successful roll-out of HIV and AIDS clinical services was observed, despite human resources for health shortages. These improvements were a result of the mostly short-term emergency response by GHI-funded Non-Governmental Organisations (NGOs) and to a lesser extent by governments. Over time, the five countries slowly implemented mid to long-term human resources strategies, sometimes in collaboration with GHIs (Cailhol et al., 2013).

Chapter Six indicates there was no clear strategy in place on how the Namibian health system would sustain some of the health workers that the Global Fund and PEPFAR had funded, once the Ministry of Health was no longer a recipient of GHI funding. The Ministry of Health started by absorbing doctors and pharmacists in the government staff structure because these were the positions that already existed on the Government's Staff Establishment. The Namibian Public Service Commission first had to approve some of the health worker positions that had been developed specifically to facilitate the implementation of GHI-supported Ministry of Health interventions. There was uncertainty expressed by respondents representing the two GHIs and respondents from the Ministry of Health on how long it would take for some critical health worker positions – such as those relating to monitoring and evaluation – to be approved by the Public Service Commission.

Ministry of Health officials also confirmed that there was no guarantee that staff positions would be approved by the Public Service Commission just because the Global Fund and PEPFAR had funded them. As a result, several respondents from the DSP expressed concerns that Ministry of Health might not absorb various staff positions, which had been critical to implementing GHI interventions (but did not have corresponding positions within the Ministry). Respondents from Ministry of Health, however, also expressed frustration that when the Global Fund and PEPFAR headquarters decided to reduce their HR budgets to

Namibia, they did not consult the Namibian Government. During the RCC grant, the Global Fund mandated a reduction in the levels of salaries that were allowable for all workers associated with the Global Fund grant in Namibia. These wage levels were not problematic during the Round 2 grant. While during PEPFAR phase 2, the decision was made by PEPFAR administrators to reduce the human resources budget to the Ministry of Health and to Namibia at large.

8.2.3 Civil Society Engagement and the Global Fund

Chapter seven examines the Ministry of Health's relationship with civil society organisations as associated with Global Fund support to Namibia. The results presented in chapter seven indicate that funding from the Global Fund that started during the Round 2 grant created an opportunity for civil society organisations to become more engaged in planning for and implementing HIV and AIDS interventions in Namibia. When the financial support from the Global Fund in the country was on the decline, as reflected by circumstances during the RCC grant, there appeared to be a lot of political uncertainty on how the country would sustain the efforts of civil society organisations that were funded by the GHI.

Before the arrival of Global Fund support in the country, the Namibian Government had pre-established national policy implementation structures through which it sought to coordinate the

multi-sector response to HIV and AIDS. In particular, the National Strategic Framework for HIV and AIDS (NSF) emphasises the Namibian Government's commitment to strengthening both the operational and financial capacity of CSOs addressing HIV and AIDS in the country. The data indicates, however, that in the presence of Global Fund support, the country had difficulty in meeting the NSF goals of a coherent and efficient multi-sector coordinating strategy. In the face of declining funding from the Global Fund, the Namibian Government also did not stay true to its commitment to assist other stakeholders in accessing sustainable financial resources.

As with most countries that have received its support, the Global Fund required Namibia to establish a Country Coordinating Mechanism (CCM) to apply for and oversee its grants. Although the CCM been branded in the literature as allowing for country ownership, it served more to play the functions related to the Global Fund requirements in Namibia. In comparison to the Namibia's pre-existing multi-sector HIV and AIDS coordination structure, NAEC, respondents viewed the CCM as being more functional and thus more effective. They criticised NAEC, which is meant to be coordinated by the DSP for not meeting as frequently as national policy requires. As told by respondents in Namibia, even though NAEC members (many of whom were also CCM members) were supposed to meet four times a year, the meetings often did not occur more than twice a year.

Respondents in Namibia believed that there was a need for leaner HIV and AIDS coordination structures with clear guidelines on how external funders such as GHIs would engage in the planning processes in Namibia. Respondents were in particular critical of the fact the same organisations that were part of the Global Fund CCM were already members of NAEC. Thus it was viewed contradictory to the principles of country ownership and alignment when the CCM and NAEC fundamentally had the same objectives concerning HIV and AIDS, yet different meetings were held for the two groups. The CCM mainly discussed Global Fund issues. It appears, however, that those same people who were able to make to CCM meetings could have easily made it to NAEC meetings to discuss Global Fund issues in the context of existing national priorities.

By requiring Namibia to establish a CCM, the Global Fund appears to have wasted an opportunity for the country to strengthen its existing multi-sector coordination structures for HIV and AIDS. For most of the Round 2 grant, the Ministry of Health chaired the CCM, and also served as its Secretariat. However, citing issues of conflict of interest throughout the Round 2 grant, the stewardship role of the Ministry of Health on the CCM was taken away by the time the country received the RCC grant. If the goal of the CCM is to ensure effective multi-sector coordination and country ownership as initially articulated by the Global Fund, then perhaps the Ministry of Health should not have been side-

lined. Thus the Global Fund emphasis in Namibia should have been on ensuring that its coordination activities were aligned with the Namibian Government's goals for HIV and AIDS multi-sector engagement.

The case study of the Ministry of Health indicates that Global Fund's application and implementation process overemphasise the involvement of a variety of stakeholders that is more concerned with quantity over quality. Policymakers within the Ministry of Health recognised that civil the society organisations that had been funded by the Global Fund were critical to supporting the Ministry's medically focused response to HIV and AIDS. These groups carried out the behavioural components of the HIV and AIDS interventions and served as information providers and advocates for people to access the Government run treatment services.

The delays in Global Fund disbursements and decrease in financial support to Namibia, however, had an adverse impact on the operations of civil society organisations in the country. NANASO, which was added as a second PR to the RCC grant to oversee civil society activities, in conjunction with the Ministry of Health, was one of the organisations negatively impacted. Several respondents in Namibia indicated that the decrease in funding threatened the non-medical interventions for HIV and AIDS that had been driven by civil society. On the other hand, civil society organisations in Namibia seemed to have unfair expectations of the Ministry of Health.

In various ways, the CCM members agreed with taking away the multi-sector coordination role of the Ministry of Health because the Global Fund had signalled that this reflected a problem of conflict of interest because the Ministry of Health was also an implementer of HIV and AIDS interventions. When funding from the Global Fund had become constrained, these same civil society organisations expressed frustrations that Ministry of Health was not doing more to help them fill the gaps in financial resources that would occur in the event of a total cessation of funding from the Global Fund.

When financial support from the Global Fund was on the decline during the RCC, the expectation was for the Ministry of Health to make up for the money that the Global Fund would no longer make available to civil society organisations in Namibia. Since it relied on the Government budget, civil society stakeholders criticised it for not doing more to help them access alternative and potentially more sustainable sources of funding. As described by respondents from civil society groups that were recipients of financial support from the Global Fund, the GHI funding created a market and demand for HIV services. It, however, also created a dilemma in which there is a demand for services, for which provision was not potentially sustainable.

Chapter Seven shows that concerning multi-sector coordination and engagement, the Global Fund's objectives were both aligned and misaligned with the aims set out by the Namibian Government. On the

one hand, similar to the Namibian Government, the Global Fund was attempting to ensure that the country had the sense of ownership in defining how its funds would be used. The Global Fund claims to want to ensure that decisions around funding and the application for its grant reflected the existing capacities and interests of those that would be receiving the funding. It did this by encouraging that a wide range of stakeholders should be part of the conversation. Yet, by insisting that everyone have an equal voice, the Global Fund was responsible for sidelining the role of the Ministry of Health. By seeking to limit the Ministry of Health's leadership role in the multi-sector coordination of its grant in Namibia, the Global Fund's policy of conflict of interest did not align with how things already operated in Namibia.

Chapter Seven illustrates that although the Global Fund has branded the CCM as allowing for country ownership, in Namibia, it mainly served the requirements of the GHI. The data presented in this chapter indicates that even when governments manage to engage with multi-sector efforts in the presence of donor support, this collaboration can be temporary. Health sector stakeholders will then return to their pre-funding status quo, in which different agencies work independently (Banteyerga et al., 2006; Dodd and Lane, 2010; Hill et al., 2012). As a PR to the Global Fund grants and the Secretariat of the PMU, the Ministry of Health engaged with CSOs in the implementation of interventions through what appears to be an artificial relationship driven by the

availability of Global Fund money. Lots of signatures during consultation processes, unique to the Global Fund, are therefore not reflective of a larger commitment from the Namibian Government to continually engage with and support CSOs. This lack of long-term commitment is reflected in the Ministry of Health's response when it became apparent that a loss in Global Fund support might jeopardise the activities of CSO recipients.

8.3 Health System Implications of HIV and AIDS GHIs in Namibia

The Namibian Government has defined its HIV and AIDS response regarding policy and institutional structures (Government of the Republic of Namibia, 2008; MoHSS: DSP, 2010). It, however, does not appear to enforce its objectives in the presence of GHIs. The results chapters indicate that it took the transition of Global Fund and PEPFAR funding in Namibia for the Ministry of Health to start considering how it would integrate the parallel capacity that was developed by GHIs into existing Ministry of Health structures. GHIs largely operate in a vertical manner, bypassing country systems; they compete for the limited human resources; they influence country policies; and they are not always harmonised with other donors (Mwisongo and Nabyonga-Orem, 2016). GHI approaches have not changed substantially over the years, but there has been an evolution concerning global attempts to manage the interactions of funders with country health systems. Thus the challenge

is for recipient countries to hold them accountable to the goals of international policies such as the Paris Agenda.

Weaknesses in health systems contribute to a failure to improve health outcomes, even with increased official development assistance. At the national level, it is essential to increase capacity to manage and deliver services, situate interventions firmly within national strategies, ensure effective implementation, and coordinate external support with local resources (Balabanova et al. 2010). Due to the availability of treatment, HIV and AIDS has now become a chronic health issue in many countries, rather than the death sentence it used to be before the advent of initiatives such as the Global Fund and PEPFAR. The chronic nature of HIV and AIDS require sustainable implementation of health services and availability of the appropriate workforce (Bennett et al., 2015; Kelly and Birdsall, 2010; Marten, 2015; Mills et al., 2010).

Since HIV and AIDS are a long-term problem, solutions to address them need to also have a long-term potential for impact (Hecht et al., 2010; Johri et al., 2012). It is hard to translate increases in funding to better HIV and AIDS outcomes in the long-term if other essential health services remain underfunded. GHI funding, if it also contributes to broader health system improvements, may potentially leverage better HIV and AIDS outcomes (Druce and Dickinson, 2008a; Palen et al., 2012; Vujicic et al., 2012; Windisch et al., 2011). If immediate results are the aim of external financial resources, without adequate attention to

strengthening the health system in whole, this can create challenges for the continuity of access to those services. Rather than just investing in HIV and AIDS-specific systems, it is in the best interest of international actors to invest in strengthening overall health systems.

Namibia was able to achieve significant gains in decreasing HIV prevalence during the period covered by this thesis (MoHSS et al., 2010; MoHSS and Health Systems 20/20, 2008). As one individual from the Ministry of Health put it, support from the Global Fund and PEPFAR "helped us to reverse the tide as far as HIV was concerned". Thus with the assistance from the Global Fund and PEPFAR, the Namibian health system was able to translate increased domestic funding for HIV and AIDS into improved health outcomes. Many of the interviewees, however, perceived the health systems contributions of the two GHIs as having occurred at the expense of country ownership and long-term health systems strengthening. By initially seeking to meet their objectives, donors such as the Global Fund and PEPFAR then potentially end up undermining their health goals, as well as those of the countries that receive their assistance.

Alignment and harmonisation of partnerships and GHIs are difficult in countries with the inadequate capacity to coordinate the funders (Mwisongo and Nabyonga-Orem, 2016). At the policy level for the Ministry of Health, the Division of Policy Planning (PPHRD) was the division tasked with developing and implementing the national policy for

public sector health operations (MoHSS, 2009, 2008c). There was, however, clearly a disconnect between the Policy Planning Division and DSP. Respondents from the Policy Planning Directorate, in fact, appeared to have little knowledge on how the Ministry engaged with the Global Fund and PEPFAR. This lack of collaboration between the two divisions demonstrates duplication and lack of alignment within the Ministry. A respondent from the Donor Coordination Division in PPHRD argued that if the Ministry of Health clearly defined how it sought to engage with external funders, then it would be easier for initiatives such as the Global Fund and PEPFAR to align with Ministry priorities and operations.

In Ghana, strong government leadership has facilitated the integration of Global Fund-supported activities within national programs (Atun et al., 2011). Various respondents characterised the Namibian Government as being complacent regarding ownership of GHI interventions because of the abundance of funds that were made available to the country. The interventions supported by the two GHIs were necessary and useful because their funding arrived when Namibia was at the known height of its HIV and AIDS epidemic (El Obeid, 2001; MoHSS, 2008a). Several respondents in Namibia argued that the Ministry of Health needed to better prepare for both the arrival and departure of external funding to the health system. Respondents in Namibia, therefore, recognised that the Ministry should have had a transition plan that defined how the country would integrate the increase

in health systems capacity developed with funding from the Global and PEPFAR.

There was some recognition by policymakers within the Ministry of Health that perhaps the onus is on the government to be more clear about how it would seek to sustain the capacity of external funders such as GHIs, rather than expecting the funders to be the ones intent on facilitating this goal. By lacking clear policies for integrating and aligning support from external the Global Fund and PEPFAR, the Ministry of Health potentially left itself subject to their priorities.

8.4 Thesis Limitations and Areas for Further Research

The political dimensions of aid are central to understanding both the giving of aid and its impact at the recipient end (Riddell, 2007). In the interactions between GHIs and country health systems, the power dynamics appear more nuanced because their relationship exists under what Offe (2009) terms as a “voluntary façade.” This “depoliticises governance and fails to take into account the significant conflicts of interests and values that take place outside the negotiation room” (Offe, 2009). Offe (2009) argues that current conceptions of governance take a naïve approach, which suggests a “pure and innocent ‘power to,’ which deemphasizes the power ‘over’ other actors” (Offe, 2009, p. 551).

According to Buse and Harmer (2004), initiatives such as the Global Fund are endowed with unquestioned legitimacy because they are seen to be providing a welfare-enhancing intervention. Relationships between countries and GHIs are then automatically assumed to be reflecting the wishes and resources of those for whom the partnership is set up to help (Buse and Harmer, 2004, p. 53). In international development to health, the establishment and operations of administrative structures have influenced who wields power to make decisions on how donor funding is governed (Carbone, 2008; Dodd and Lane, 2010; Whitfield and Fraser, 2009a). Relational power dynamics regulate the types and structures that are implemented in the first place, and may also influence the ways in which those structures function once they are in place (Easterly, 2008; Riddell, 2007).

Future research relevant to the findings presented in this thesis could focus on the underlying power dynamics that govern the administration of external funding from initiatives such as the Global Fund and PEPFAR. Capacity building practitioners can be better at confronting and responding to power asymmetries present within the playing field in which they engage (de Valk, 2009; McMahon, 2010). Ubels et al. (2010) argue that it is of particular importance for practitioners associated with development aid to be aware of the location of what types of power are in play, and how they are applied. In the Ministry of Health's relationship with CDC, in particular, there was

clearly an asymmetry in decision-making power. Future research relevant to this thesis might examine questions such as: To what extent were CDC staff cognizant of the power that they possessed? How careful were they with wielding it?

Concerning the issue of power, another area for further research is a questioning of the extent to which respondents from recipients such as the Ministry of Health perceive underlying power dynamics when engaging with GHIs. There was an indication from respondents that Ministry of Health officials sometimes felt limited in their authority to make decisions and drive interventions associated with funding from GHIs. McMahon (2010) argues that this is a worthwhile issue to explore because aid recipients can sometimes subvert the power that donors seek to exercise over them (p.82).

Another limitation of this thesis is its exclusive focus on the Ministry of Health at the national level. Functionality on the national scale, however, does not always translate into functionality at the local level, which is where services are accessed (Biesma et al., 2009; Hanefeld, 2010). For instance, the Namibian Government's health policy documents emphasise a Primary Health Care that allows for health provision at the community level in direct contact with individuals, families, and communities (MoHSS, 1998; MoHSS: DSP, 2010). Aid relations with democratically elected governments involve at least three sets of actors – aid agencies, governments, and the citizenry—and this results in a three-

way relationship where each set of players has a direct connection with the other two (Whitfield and Fraser, 2009a). This research did not evaluate the opinions of citizens.

The involvement of GHIs in delivering health services depends on effective collaborative working at scales from the local to the international, and a single GHI is effectively constructed of multiple collaborations. Collaboration between local implementing agencies and departments of health involves distinct power dynamics and tensions. Managing the tension between the power to provide resources held by GHIs and the national health agency's access the populations in need of these resources is critical to ensuring partnerships that function efficiently (Jobson et al., 2017).

Concerns over whether resources are reaching those most in need, and the desire to make citizens more accountable to their governments is one of the reasons often given for making aid more efficient (Diamond, 2009; Whitfield and Fraser, 2009a). In reflecting upon the decrease of Global Fund and PEPFAR financial support to Namibia, several respondents attributed the transition to Namibia's economic ranking to a higher middle-income country during the presence of the two initiatives. Some respondents argued that the state's ranking as a middle-income country implies that Namibia should be able to pay for all the required HIV and AIDS interventions with local financial resources. Many donors made similar arguments when they withdrew their financial support to

Namibia in the late 1990s (El Obeid, 2001; European Economic Fund, 2008). Several respondents, however, argued against the economic ranking justification by reflecting that it ignores the social and economic inequalities that exist in the country. Generalised economic indicators, such as average income per capita are, not a reflection of a country's ability to meet the health needs of its citizens (Sen, 2001). The country does not necessarily do a good job of translating financial resources into human welfare.

8.5 Summary

This thesis is a case study of how GHIs impact on the national health systems of the countries that receive their financial support. The Namibian case study as presented, adds to knowledge on how the operations of GHIs can influence the national health system context. The Namibia context is also important because there is limited academic research on the country's health sector, particularly about GHIs. Studies of the Global Fund and PEPFAR have tended to take a cross-sectional approach to understanding their impacts, in a manner that emphasises their original scale up goals. This thesis expands on the health system understanding of Global Fund and PEPFAR impacts at country level by taking into account both the rise and decline in GHI funding to Namibia.

The Namibian Government has constructed HIV and AIDS as requiring a long-term approach. At the increase of Global Fund and PEPFAR funding to Namibia, the rapid objectives of the two initiatives governed their operations with the Ministry of Health. For the most part, when the two GHIs began to operate in Namibia, their focus appears to have been on scaling up access to HIV and AIDS as quickly as possible. The initial operations of the Global Fund and PEPFAR therefore eventually had negative implications for the sustainability of the institutional capacity that Namibia developed with GHI support.

The findings presented in the thesis support conclusions that the priorities of GHIs may govern their interactions recipient countries at the expense of health system ownership. Namibia first received financial support from the Global Fund and PEPFAR due to an emergency demand for HIV and AIDS services that was defined at the global level. The founding policies of the Global Fund and PEPFAR indicate a naive expectation that a substantial amount of GHI funding would quickly solve the world's HIV and AIDS troubles in the most heavily burdened places such as Namibia. Following the first few years of operations, the Global Fund and PEPFAR sought to pivot away from their initial focus on emergency mode and rapid scale-up of interventions, to a greater focus on sustaining their successes. The emergency is, however, not over for countries such as Namibia even though the GHIs have changed their minds about the nature of the problem.

As far as ownership was concerned, there was a perception among the Namibians interviewed for the thesis that the Global Fund and PEPFAR could have been better aligned their operations with existing national systems and objectives from the onset. Funding from two GHIs could have then been used to better address the existing health system deficits in the country. This thesis has shown that the drive for results ended up undermining the institutional autonomy of the Ministry of Health and thus led to a missed opportunity to integrate increased operational capacity into existing Ministry of Health structures.

9. Conclusions

9.1 Introduction

This thesis is concerned with evaluating the Namibian Ministry of Health's ability to steer the HIV and AIDS program at the national policy level in its engagement with the Global Fund and PEPFAR. It examines how the relationship of the two GHIs with the Ministry of Health changed over time as the emphasis on their engagement with Namibia shifted from a focus on the rapid scale-up of financial resources to address HIV and AIDS services. Their attention moved to a greater focus on country ownership and health system sustainability, which was also associated with a decrease in the financial support made available to countries like Namibia.

The thesis has a thematic sub-focus on the Ministry of Health's functions of financial flows and management, human resources management, and civil society engagement. It examines the operational structures and processes that were adapted in relation the two initiatives at the rise of their funding to Namibia. The thesis then evaluates the implications that these structures and processes had for the Ministry of Health at the point at which Namibia faced a decline in financial support from the two GHIs. This study, therefore, captures the transition of Global Fund and PEPFAR funding to Namibia.

9.2 Summary of Thesis Findings

Chapter One frames the thesis around the concept of country ownership and autonomy as reflected in the origins and objectives of the Global Fund and PEPFAR, as well as international efforts to make global health aid more effective as represented by global policy attempts to encourage country ownership through the Paris Agenda. Chapter One also introduces the relevance of using Namibia as a case study for understanding the country-specific interactions of the Global Fund and PEPFAR on country ownership. Namibia is relevant because it was initially positioned as the ideal recipient of Global Fund and PEPFAR financial support when the objectives of the two GHIs were focused on rapidly scaling-up HIV and AIDS interventions at the global level. The country was then directly impacted when the goals of the two initiatives then changed to encourage more ownership and sustainable health systems support.

Chapter Two reviewed the literature on the country-specific effects of Global Fund and PEPFAR funding. The chapter focuses the ownership and autonomy discussion on the three sub-themes of financial flows; human resources management; and civil society engagement. It evaluates the extent to which existing literature has perceived the two initiatives as having facilitated or discouraged country ownership. Chapter Two also

reflects on the health system implications of Global Fund and PEPFAR practices, as associated with their impacts on country ownership.

Chapter Three focuses on the research design underlying the data presented in this thesis. It justifies the use of the case study design and its various components that were taken into account to provide this research with both internal and external validity. Given my birth nationality as a Namibian, the chapter concludes with an argument for embracing the subjectivity of the researcher in the collection and analysis of data for qualitative case studies.

Chapter Four presents Namibia's national health and HIV and AIDS policy background to provide the context of the results presented in chapters five, six and seven. The chapter introduces the Namibian Government's policy and institutional role in addressing HIV and AIDS in the country. It also provides a descriptive background of Namibia's engagement with the Global Fund and PEPFAR in relation to the funding received and the agencies in the country associated with the two GHIs.

Chapter Five is the first of the three results chapters that primarily uses interview data to examine the concept of ownership and autonomy at the rise and fall of GHI funding of Namibia. It focuses on financial flows in the Ministry of Health's engagement with the Global Fund and PEPFAR. Chapter Five shows that the arrival of Global Fund and PEPFAR funding was associated with the establishment of financial flow processes and structures to cater to the accountability requirements

of the two GHIs. The Global Fund required the creation of a Programme Management Unit (PMU) in the Ministry of Health, while PEPFAR funding was channelled and managed through the structures of the Centres for Diseases Control (CDC) offices in Namibia.

Chapter Six examines the structures and procedures that were used to recruit human resources in the Ministry of Health's engagement with the Global Fund and PEPFAR. As done in Chapter Five, Chapter Six compares and contrasts implications for country ownership and autonomy of Global Fund and PEPFAR practices at the rise and fall of GHI funding to Namibia. Chapter Six shows that the recruitment practices associated with Global Fund and PEPFAR funding to the Ministry of Health resulted in the existence of three different categories of workers, all working for the Ministry of Health on HIV and AIDS interventions. This separation of human resources recruitment ended up then creating challenges for the Ministry's ability to sustain the increased human resources capacity when it was faced with a decline in funding from both the Global Fund and PEPFAR.

Chapter Seven examines the Ministry of Health's engagement with HIV and AIDS civil society organisations in Namibia, as mediated by the Global Fund. On paper, the national coordination structures for Namibia's multi-sector response to HIV and AIDS are relatively well-defined through the NSF. The data presented in Chapter seven shows, however, that in the presence of Global Fund support, the Ministry of

Health had difficulty in meeting the NSF goals of a coherent and efficient multi-sector coordinating strategy.

Chapter Eight brought together the issues of country ownership and organisational autonomy presented in the results sections and then links them to review of literature presented in chapter Two. Chapter Eight argues that the practices of the Global Fund and PEPFAR at the rise of their funding to Namibia discouraged country ownership and autonomy, and indicate adverse implications for sustainable capacity and health systems strengthening for the Ministry of Health.

This thesis primarily seeks to contribute to research that examines the country level interactions of GHIs such as the Global Fund and PEPFAR. It is a critical assessment of how recipient governments can retain ownership and autonomy of their health systems in the presence of substantial funding from GHIs. The thesis has shown that the initial interactions between the Namibian governments were driven by the short-term goals of the two HIV and AIDS GHIs. The tensions of this initially myopic approach of providing external assistance for health were apparent in some of the health system challenges that the Ministry of Health faced due to a decline in funding by the two initiatives.

9.3 Concluding Thoughts

When the Global Fund and PEPFAR were established, there was a lot of global political enthusiasm for rapidly scaling-up HIV and AIDS treatment, prevention and care interventions in countries that needed the support. The enthusiasm was also accompanied by the availability of financial resources. The Namibia case study shows, however, that the GHIs were not able to sustain the magnitude of funding that they had initially provided to the country. The data presented in this thesis shows that when the Ministry of Health started its relationship with the Global Fund and PEPFAR, structures and processes for financial flows, human resources and civil society engagement (for the Global Fund) appear to have driven by the demands of the two initiatives.

The Ministry of Health's existing structures and processes were initially perceived as being weak by the GHIs, and thus a potential hindrance the originally stated objectives of the two initiatives to rapidly scale-up HIV and AIDS interventions. Rather than seeking to strengthen the perceived health system weaknesses by enhancing them, Global Fund and PEPFAR funding to Namibia was used to circumvent the Ministry of Health's existing structures. In Namibia, parallel administrative structures appear to have been tenable and unproblematic as long as there was a continuous stream of money from the Global Fund and PEPFAR to prop them up.

This thesis has shown that structures and operations for financial flows, human resources and civil society engagement that were funded through the Global Fund and PEPFAR initiatives facilitated the initial rapid scale-up of HIV and AIDS for the Ministry of Health. The original nature of operations of the structures funded through the two initiatives, however, undermined the Ministry of Health's autonomy to make decisions on behalf of the Namibian public health sector. The Namibian Government was also characterised by various respondents as being complacent concerning ownership and ignoring its implications for intervention sustainability because of the abundance of funds that were made available to the country through the Global Fund and PEPFAR.

The increased health system capacity achieved in Namibia with financial support through the two GHIs, therefore, appeared to be unsustainable when their funding to the country was on the decrease. When both GHIs sought to decrease financial support to Namibia, the Ministry of Health was expected to take on responsibility for management functions that had initially been closely aligned with the requirements of the two initiatives. Perhaps a greater promotion of national ownership in Namibia's engagement with the Global Fund and PEPFAR funding would have reflected a funding transition that indicated more potential for the country to sustain the increased health system capacity achieved with external support.

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*Appendix 1: Ministry of Health Activities Supported by Global Fund and PEPFAR
(2008-2010)*

HIV and AIDS Intervention Plan: 2008 to 2010			
Directorate Special Programmes: Ministry of Health			
Objectives	Activities	Output	Partners
Provision of HAART			
Increase the number of eligible patients receiving HAART from 60,700 to 71,900 by March 2010	Expand the number of facilities providing HAART through outreach services and IMAI from 58 services points to 70	ART service points increased to 70	MoHSS-DSP,GF, CDC
	Renovate 10 health facilities	10 Health Facilities renovated	MoHSS-DSP,Global fund, CDC
	Provide post exposure prophylaxis to all exposed clients attended to at Health facilities	PEP provided to all exposed clients presenting at health facilities	MoHSS-DSP,Global fund,CDC
	Train 240 family members to serve as treatment supporters for patients on HAART	240 EPTs trained	MoHSS-DSP,Global fund,CDC
Laboratory services			
Strengthen capacity to provide bio-clinical	Pay for all HIV-related bio clinical monitoring tests provided by NIP	Appropriate bio-clinical monitoring for quality	MoHSS-DSP,GF, CDC

monitoring tests to all HIV positive clients		HIV management provided	
	Procure and distribute point of care laboratory equipment	Point of care bio-clinical monitoring equipment procured and distributed	MoHSS-DSP,GF, CDC
Medical supplies			
Increase the capacity of pharmaceutical services to provide medical supplies for eligible clients from the projected 60,700 to 71,900 by March 2011	Procure adequate ARV medicines	Adequate ARV medicines provided	MoHSS-DSP, GF,CDC
	Purchase and distribute ART equipment	ART equipment procured and distributed	MoHSS-DSP,Global fund,CDC
PMTCT-Plus services			
To provide comprehensive care, treatment and support to at least 80% of all HIV positive mothers	Actively support and create linkages to Treatment Services between ANC, Postnatal and MCH	Linkages established	MoHSS-DSP,Global fund,CDC

identified through the PMTCT programme			
	Offer HIV DNA-PCR test to 25% of HIV-exposed babies within 8 weeks of birth	25% of HIV exposed babies tested for HIV within 8 weeks of birth	MoHSS-DSP, Global Fund, CDC, MSH, UNICEF
	Offer routine family planning and counseling services to all HIV positive women	Family planning and counseling services offered to all HIV positive women	MoHSS-DSP, Global fund, CDC
Public Awareness			
To increase the knowledge of general population on treatment, care and support	produce video clips on treatment, care and support	Video clips produced	MoHSS-DSP, Global fund, CDC
	Radio/TV talk shows	Radio/TV shows done	MoHSS-DSP, Global fund, CDC
	Develop information package for the deaf and the visually impaired	Information package developed	MoHSS-DSP, Global fund, CDC
	Conduct male conferences and create male platform	Conference conducted and reports available	MoHSS-DSP, Global fund, CDC

	Host the 2009 PEPFAR implementers' meeting	Meeting hosted in Namibia	MoHSS-DSP, Global fund, PEPFAR
	Publish and distribute an HIV newsletter biannually	HIV newsletter published and distributed	MoHSS-DSP, Global fund, PEPFAR
	Commemorate the National Health Week 26-30 November 2008.	Event conducted	MoHSS-DSP, Global fund, CDC
	Commemorate the World AIDS Day 1st of December 2009	Event conducted	MoHSS-DSP, Global fund, CDC
Capacity development			
To improve management capacity and professional skills	Train health workers on comprehensive HIV case management	Clinical Staff trained in comprehensive HIV management	DSP - GF, CDC
	Provide bursaries for doctors, nurses, social workers, pharmacists and pharmacist's assistants	Students awarded bursaries to attend medical training	MoHSS-DSP, Global fund, CDC
	Staff to attend short courses in M&E, HIV/AIDS, TB	Staff trained	MoHSS-DSP, Global fund, CDC
	Send Staff to international conferences on TB, HIV (IGASA, IUATLD)	Conferences attended and reports available	MoHSS-DSP, Global fund, CDC
	Conduct a team building workshop for case management staff	Workshop conducted	MoHSS-DSP

	National staff to attend long-term trainings (MPH)	Staff enrolled for long term training courses	MoHSS-DSP,Global fund, CDC
QUALITY OF CARE			
To assess and improve the quality of HIV care services provided in all ART health facilities.	Extend the coverage of the HIVQUAL project to all ART sites	HIVQUAL rolled out to all ART sites	MoHSS-DSP,CDC,
	Print and distribute updated training manuals for HIVQUAL Namibia.	Updated training manuals distributed	MoHSS-DSP,CDC
	Train Healthcare workers in HIVQUAL	Health workers trained	MoHSS-DSP,CDC
Collaborative TB/HIV AIDS Services			
To strengthen TB/HIV services at all levels	Increase intensive TB Case finding among HIV positive clients	Health workers trained	MoHSS-DSP,Global fund,CDC
	Increase the provision of TB-IPT to HIV positive clients	TB-IPT provided to eligible Clients	MoHSS-DSP,Global Fund,CDC
	Participate in infection control guideline development	Guidelines developed for infection control	MoHSS-DSP,Global fund,CDC
	Participate in training of health workers on	Health workers	MoHSS-DSP,Global

	infection control measures	trained	fund,CDC
	Sensitise RACOC + RMT members on TB/HIV co-infection during debriefing meetings (sup visits)	Meetings conducted	MOHSS
	Participate in consultation meetings between NTCP and TB on renovation of facilities	Meetings attended	MOHSS,CD C,GF
	Support 2 MOST TB/HIV trainings	Trainings supported	MOHSS,CD C,GF
	Participate in the biannual national HIV and TB review meetings	Meetings attended	MOHSS,CD C,GF
Programme Management			
Improve programme management	Conduct Supervisory support visits to ART sites	visits conducted	MoHSS-DSP,Global fund,CDC
	Conduct Supervisory support visits to IMAI sites	visits conducted	
	Provide onsite Clinical mentoring for IMAI	Mentoring visits conducted	
	Collaborate with M & E subdivision in training staff in	Training done	MoHSS-DSP,Global fund,CDC
	Conduct technical support visits to all ART sites implementing HIVQUAL	Support visits done all the 16 sites.	MoHSS-DSP,CDC
	Conduct annual TB, HIV/AIDS review meeting	meeting conducted	MoHSS-DSP,Global fund,CDC

M & E			
Strengthen Monitoring and Evaluation of the HIV program	Carry out a study on adherence to ART	Adherence study conducted	MoHSS-DSP, Global fund, CDC
	Conduct Sentinel sero-Survey 2010	Sentinel sero survey conducted	MoHSS-DSP, Global fund, CDC
	Develop and implement an M&E plan for HIV Case management	Plan developed and implemented	MoHSS-DSP, Global fund, CDC
	Develop and implement an M&E plan for HIV/TB collaborative activities	Plan developed and implemented	MoHSS-DSP, Global fund, CDC
	Conduct HIV drug resistance survey	HIV drug resistance survey conducted	MoHSS-DSP, Global fund, CDC
	Strengthen the reporting system for adverse events associated with ART to TIPC	reporting system strengthened	MoHSS-DSP, CDC



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08 March 2012

OFFICE OF THE PERMANENT SECRETARY

Ms Liita Naukushu
PHD Candidate

Dear Ms Naukushu

**RE: ATTACHMENT TO THE DIRECTORATE OF SPECIAL PROGRAMS (DSP) FOR RESEARCH:
MARCH 2012**

The Ministry of Health and Social Services hereby would like congratulate you on the approval of your Research Proposal by the Ministerial Research Committee.

However, we are also delighted to inform you that your request for attachment to DSP has been approved. Therefore, you have been allocated to Response Monitoring & Evaluation Sub-division in DSP for the period as from 12 March 2012.

In addition, in case your research activities may require travelling to the regions, arrangement and support will be made accordingly

We wish you a successful undertaking

Yours sincerely


.....
Mr. Kahijoro Kahugere
Permanent Secretary
Ministry of Health and Social Service

Appendix 3: Information for Participants

Ms. Liita Naukushu
PhD Candidate, Global Public Health Unit
Social Policy, School of Social & Political Sciences
University of Edinburgh
Email: L.Naukushu@sms.ed.ac.uk
Tel: +264818188324 (Nam), +447821591776 (UK)



Information for Participants

My name is Liita Naukushu and I am a PhD student in International Public Health Policy at the University of Edinburgh. My research focuses on Namibia to examine how Global Health Initiatives (GHIs) engage with the national health priorities of developing countries. It places a particular emphasis on how the Global Fund to Fight AIDS, Malaria and Tuberculosis (Global Fund), the U.S President's Emergency Plan for AIDS Relief (PEPFAR) and the Ministry of Health and Social Services (MoHSS) have related to each other in current rounds of funding.

The primary sources of data for my research are one-on-one interviews and policy documents. These data will be used to understand the operational and strategic frameworks that govern GHI partnerships with MoHSS in the Namibian health system. I would please like you to contribute to my research through an interview. Your input is important because of your previous or current association with Global Fund and/or PEPFAR activities in Namibia.

The interview should take no more than 1 hour. It will be recorded with a digital recorder, in order to enable me to best recall and represent your contribution. Any information you give me will be made anonymous. I will respect your decision if you do not want the conversation recorded, do not want to respond to a question, or if you wish to withdraw your participation from the research at any stage. The results of the research may be published in academic journals and presented at conferences.

If you have read and understood the information provided, and still wish to take part in my research, I will ask you to sign a consent form before the interview.

Thank you,

Liita Naukushu

Dr. Anuj Kapilashrami (Supervisor)
Lecturer, Global Public Health Unit
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Ms. Ella Shihepo (Namibian Contact)
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Appendix 4: Consent Form

GLOBAL PUBLIC HEALTH UNIT
Social Policy, School of Social & Political
Sciences University of Edinburgh
Chrystal Macmillan Building, 15a George Square,
Edinburgh, EH8 9LD



CONSENT FORM

I have read and understood the information provided, and I fully to consent to participate in the above titled PhD research.

I understand that I am not obligated to contribute to this research and I can withdraw my participation at any stage before, during or after the interview.

By signing this form, I consent to the following:

1. I will participate in a one-to-one interview with the researcher
2. Any information I provide can be recorded in audio and/or written form for later use by the researcher
3. The information I provide can be disseminated in any form relevant to the research as long as my name is not quoted and anonymous quotes cannot be directly linked to me

By signing this form, I acknowledge that I understand everything in the information sheet and consent form.

Name of the participant: _____

Signature of Participant: _____

Signature of researcher: _____

Date of interview: _____

Researcher: Liita-Iyaloo Naukushu

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Appendix 5: Background Questions for DSP, Global Fund, CDC Namibia

Background Questions for DSP, PEPFAR and Global Fund

DSP

1. What is the mandate of DSP?
2. What is the precursor to DSP?
3. Are there specific documents that detail the establishment of DSP? What are these?
4. How is DSP funded when compared to other Ministry of Health directorates?
5. Who have historically been the most prominent funders of DSP? What about now?
6. How did DSP's relationship with both PEPFAR and Global Fund come about?
7. How are funding priorities assessed in relation to donors?
8. How is funding channeled from funders to DSP activities? How is this different from the way government funds are channeled? How do funding channels differ between the main funders (Global Fund and PEPFAR)?
9. What is the hiring process for the various people that work in DSP?
10. Which Ministry of health departments are closely associated with DSP and in what capacity?
11. What are the main mechanisms of accountability for DSP to the Ministry and its donors? What documents need to be produced on a regular basis?

PEPFAR/Global Fund

1. How did PEPFAR/Global Fund come about?
2. Are there specific documents that detail the purposes and evolution of PEPFAR/Global Fund? What are these?
3. What is the administrative structure of PEPFAR/Global Fund at a global and a Local level?
4. How is determined for a country to become a PEPFAR/Global Fund recipient?
5. Who are the main recipients of funding from PEPFAR/Global Fund at national level? How are they determined?
6. Can you please add to my drawing of network of actors (Provide drawing)?
7. If at all, how have the primary and sub-recipients changed since the inception of PEPFAR/Global Fund in Namibia?
8. What are the current and historical functions of funding from PEPFAR and Global Fund in Namibia?
9. If any, what is the established protocol for hiring staff for PEPFAR/Global Fund projects in Namibia?
10. How do PEPFAR/Global Fund disbursements occur from a Global to local sub-recipient level?
11. What are the reporting mechanisms for funding from PEPFAR/Global Fund? What are the main document outcomes?
12. What is the future of funding from Global Fund and PEPFAR in in Namibia?

Overview of the Partnership

1. Can you please introduce yourself?
 - a. Your position, how long you have been with the organisation, what is your general job description
2. Who are main donors to the Ministry of Health?
 - a. What activities do they fund within your department?
3. What is your individual/department's engagement with Global Fund/PEPFAR money in the Namibian health sector?
4. As you understand them, what are the objectives of the Global Fund/PEPFAR in funding activities in Namibia and the Ministry of Health?

Governance

5. Through what systems does the Ministry ensure efficient utilization of funds and effective monitoring of programme implementation?
6. What are the key formal mechanisms for governing the Ministry's utilisation of funds, as mandated by Global Fund and PEPFAR (Cooperative agreements, TORs, Country Operational Plans, etc)?
 - a. Can you please describe your individual/department involvement in the planning process that led to the establishment of the formal documents for these mechanisms in the current rounds of funding?
7. How have existing Ministry of Health governance structures been adjusted to accommodate Global Fund/PEPFAR governance requirements?
8. In your experience, what have been some of the Ministry's challenges and strengths in meeting the demands Global Fund/PEPFAR? [Please give examples]

Health Sector Alignment

9. What national strategies, policies, or frameworks do you view as governing priority-setting in the Namibian health sector?
10. To what extent do you think activities in the Namibian health sector over the past ten years have been driven by GHIs such as PEPFAR/Global Fund, rather than the Ministry of Health? [Please give examples.]
11. How would you define alignment of donor-funded activities with existing country health systems?
 - a. To what extent do you think there could have been better alignment between the priorities of Global Fund/PEPFAR and those of the Ministry? Which areas of the health sector would you have emphasized and in what ways?
12. I understand that you are part of the PEPFAR Steering Committee/GF Country Coordinating Mechanism [For CCM/Steering Committee members].
 - a. To what extent does the platform present opportunities for coordination of HIV activities and alignment with the health sector?

Recruitment and Technical Advisors

13. Technical Advisors (TAs) appear to be a prominent feature of activities funded by Global Fund/PEPFAR.
 - a. Based on your own experiences, what have you found to be the strengths and weaknesses in the use of TAs for Global Fund/PEPFAR activities?
14. I understand that CDC recruits and manages all project staff using the recruitment/HR agency, Potentia.
 - a. What was the Ministry's involvement in this decision?
 - b. To what extent does the Ministry work with Potentia on HR recruitment issues?
15. What implications do you think the use of TA's and these different staffing processes have for long-term human resources development in the Namibian health sector?

Perceptions of Partnerships

16. As you understand them, what are the main functions of the Ministry of Health in the Namibian health sector?
17. To what extent does the Ministry of Health represent the priorities and needs of the Namibian people?
 - a. What do you view as the Ministry's biggest strengths and weaknesses?
18. To what extent has the presence of Global Fund/PEPFAR created opportunities and/or challenges to the Ministry, as well as the Namibian Health Sector?
19. I understand that that PEPFAR has already communicated its intention to decrease funds and there is uncertainty around Global Fund money
 - a. What do you understand as the reasons for this transition?
 - b. What Ministry and health sector activities do you think will be most impacted by this phase out and uncertainty? In what ways?
20. In future, what do you think health sector stakeholders (including your agency) should do differently or duplicate, if Namibia is presented with similar levels of disease-specific funding as provided by PEPFAR/ Global Fund?

Interview Guide (Global Fund and PEPFAR)

Overview of the Partnership

21. Can you please introduce yourself?
 - a. Your position, how long you have been with the organisation, what is your general job description
22. What activities is your organization currently funding in the Ministry of Health and/or other agencies in the Namibian health sector?
23. As you understand them, what are the objectives of your organisation in funding activities within the Namibian health sector, and the Ministry of Health (if stated in previous question)?

Governing and Coordination

24. Through what systems does your organisation ensure efficient utilization of funds and effective monitoring of programme implementation?
25. What are the key formal mechanisms for governing the Ministry's utilisation of your funds, as agreed with the Ministry (Cooperative agreements, TORs, Country Operational Plans, etc)?
 - a. Can you please describe your individual/department involvement in the planning process that led to the establishment of the formal documents for these mechanisms in the current rounds of funding?
26. In your experience, what have been some of the Ministry's challenges and strengths in meeting agreed upon expectations? [Please give examples]

Health Sector Alignment

27. What national strategies, policies, or frameworks do you view as governing priority-setting in the Namibian health sector?
28. To what extent do you think activities in the Namibian health sector over the past ten years have been driven by GHIs such as PEPFAR/Global Fund, rather than the Ministry of Health? [Please give examples.]
29. How would you define alignment of donor-funded activities with existing country health systems?
 - a. To what extent do you think there could have been better alignment between the priorities of Global Fund/PEPFAR and those of the Ministry? Which areas of the health sector would you have emphasized and in what ways?
30. I understand that you are part of the PEPFAR Steering Committee/GF Country Coordinating Mechanism [For CCM/Steering Committee members].
 - a. To what extent does the platform present opportunities for coordination of HIV activities and alignment with the health sector?

Recruitment and Technical Advisors

31. Can you please discuss the role that technical advisors have played in current rounds of your funds to the Ministry of Health?
32. Based on your own experiences, what have you found to be the strengths and weaknesses in the use of TAs in your partnership activities in Namibia?
33. I understand that CDC recruits and manages all project staff using the recruitment/HR agency, Potentia.
 - a. What was the Ministry's involvement in this decision?
 - b. To what extent does the Ministry work with Potentia on HR recruitment issues?
34. What implications do you think the use of TA's and these different staffing processes have for long-term human resources development in the Namibian health sector?

Perceptions of Partnerships

35. As you understand them, what are the main functions of the Ministry of Health in the Namibian health sector?
36. In your opinion, to what extent does the Ministry of Health represent the priorities and needs of the Namibian people?
 - a. What do you view as the Ministry's biggest strengths and weaknesses?
37. To what extent has the presence of Global Fund/PEPFAR created opportunities and/or challenges to the Ministry, as well as the Namibian Health Sector?
38. I understand that your agency is phasing out/reducing funds to the Namibian health sector.
 - a. What are the reasons for this transition?
 - b. What Ministry and health sector activities do you think will be most impacted by this transition? In what ways?
39. In future, what do you think health sector stakeholders (including your agency) should do differently or duplicate, if Namibia is presented with similar levels of disease-specific funding as provided by PEPFAR/ Global Fund?

Interview Guide (Other Namibian Health System Stakeholders)

Background

40. Can you please introduce yourself?
 - a. Your position, how long you have been with the organisation, what is your general job description
41. What are the main functions of your organization, in relation to the Namibian health sector?
 - a. In what ways are your health sector activities different from those carried out by the Ministry of Health?
42. What is your individual/organisation engagement with Global Fund/PEPFAR money in the Namibian health sector?
43. As you understand them, what are the overall objectives of Global Fund/PEPFAR activities in Namibia?

Health Sector Alignment

44. What national strategies, policies, or frameworks do you view as governing priorities in the Namibian health sector?
45. To what extent do you believe that activities in the Namibian health sector over the past ten years have been driven by Global Fund/PEPFAR, rather than the Ministry of Health? Please give examples.
46. How would you define alignment of donor-funded activities with existing country health systems?
 - a. To what extent do you think there could have been better alignment between the priorities of Global Fund/PEPFAR and

- those of the Ministry? Which areas of the health sector would you have emphasized and in what ways?
47. I understand that you are part of the PEPFAR Steering Committee/GF Country Coordinating Mechanism [For CCM/Steering Committee members].
- a. To what extent does the platform present opportunities for coordination of HIV activities and alignment with the health sector?

Perceptions of Partnerships

48. What are the current main priorities in the Namibian health sector?
49. As you understand them, what are the main functions of the Ministry of Health in the Namibian health sector?
- a. To what extent does the Ministry of Health represent the priorities and needs of the Namibian people?
50. To what extent has the presence of Global Fund/PEPFAR created opportunities and/or challenges to your organisation, the Ministry of Health, as well as the rest of the Namibian health sector?
51. I understand that that PEPFAR has already communicated their intention to reduce funds in Namibia over the next few years and there is uncertainty around Global Fund money.
- a. What do you understand as the reasons for this transition?
- b. What areas of the Namibian health sector do you think will be most impacted by this phase out and uncertainty? In what ways?
52. In future, what do you think health sector stakeholders (including your agency) should do differently or duplicate, if Namibia is presented with similarly high levels of disease-specific funding as provided through PEPFAR/ Global Fund?

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